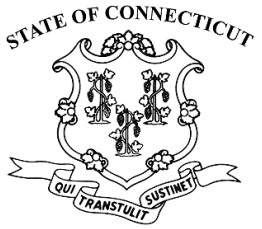


***Substitute Senate Bill No. 946***

# *Public Act No. 17-15*

***AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL AND OTHER CHANGES TO THE INSURANCE AND RELATED STATUTES.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (e) of section 5-259 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(e) Notwithstanding the provisions of subsection (a) of this section, vending stand operators eligible for membership in the state **[**employees'**]** employees retirement system pursuant to section 5-175a shall be eligible for coverage under the group hospitalization and medical and surgical insurance plans procured under this section, provided the cost for such operators' insurance coverage shall be paid by the Department of Rehabilitation Services from vending machine income pursuant to section 10-303.

Sec. 2. Subsection (c) of section 12-211 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(c) The provisions of this section shall not apply to ad valorem taxes on real or personal property, personal income taxes, fees for agents'

licenses, special purpose assessments imposed in connection with particular kinds of insurance including, but not limited to, workers' compensation assessments and Insurance Guaranty Association Fund assessments, or to premium taxes on special health care plans as defined in **[**sections**]** section 38a-564 of the general statutes, revision of 1958, revised to January 1, 2013, and section 38a-551, except in the case where another state or foreign country imposes upon Connecticut domiciled insurers retaliatory charges for such taxes, fees or assessments.

Sec. 3. Section 19a-904b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Not later than thirty days after the date that a health care provider stops accepting patients who are enrolled in an insurance plan, such health care provider shall notify, in writing, the applicable health carrier.

(b) Each health carrier shall update **[**, not less than monthly,**]** its health care provider directory or directories in accordance with the provisions of section 38a-477h.

Sec. 4. Section 38a-14 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) **[**The commissioner shall, as often as the commissioner deems it expedient, examine into the affairs of**]** For the purposes of this section, "company" means any insurance company or health care center doing business in this state, any corporation or association collecting data utilized by any such insurance company in the underwriting of insurance policies and any corporation organized under any law of this state or having an office in this state, which corporation is engaged in, or claiming or advertising that it is engaged in, organizing or receiving subscriptions for or disposing of stock of, or in any manner

aiding or taking part in the formation or business of, an insurance company or companies, or that is holding the capital stock of one or more insurance corporations for the purpose of controlling the management thereof, as voting trustees or otherwise.

(b) The commissioner shall, as often as the commissioner deems it expedient, examine into the affairs of any company. In scheduling and determining the nature, scope and frequency of the examinations, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and such other criteria as set forth in the examiners' handbook adopted by the National Association of Insurance Commissioners and in effect at the time the commissioner exercises discretion under this section.

(c) (1) To carry out examinations under this section, the commissioner may appoint one or more competent persons as examiners, who shall not be officers of, connected with or interested in any **[**insurance**]** company, other than as policyholders. The commissioner may engage the services of attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners to assist the commissioner in conducting the examinations under this section, the cost of which shall be borne by the company that is the subject of the examination.

(2) In conducting the examination, the commissioner, the commissioner's actuary or any examiner authorized by the commissioner may examine, under oath, the officers and agents of such a company, **[**health care center, corporation or association**]** and all persons deemed to have material information regarding the company's **[**, health care center's, corporation's or association's**]** property or business. Each such company **[**, health care center, corporation or association,**]** or its officers and agents **[**,**]** shall produce the books and

papers in its or their possession, relating to its business or affairs, and any other person may be required to produce any book or paper in such person's custody that is deemed to be relevant to such examination, for inspection by the commissioner, the commissioner's actuary or examiners. The officers and agents of the company **[**, health care center, corporation or association**]** shall facilitate the examination and aid the examiners in making the same so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension of, refusal of or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to subsection (c) of section 38a-41.

(3) In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the examiners' handbook adopted by the National Association of Insurance Commissioners. The commissioner may also adopt such other guidelines or procedures as the commissioner may deem appropriate.

(d) In lieu of an examination under this section of any foreign or alien insurer licensed in this state, the commissioner may accept an examination report on such insurer prepared by the insurance department for the **[**company's**]** insurer's state of domicile or port-of-entry state if (1) such state's insurance department was, at the time of the examination, accredited under the National Association of Insurance Commissioners' financial regulation standards and accreditation program, or (2) the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by such an accredited state insurance department and who, after a review of the

examination workpapers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(e) (1) Nothing contained in this section shall be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(2) Nothing contained in this section shall be construed to limit the commissioner's authority in such legal or regulatory action to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination.

(3) Not later than sixty days following completion of the examination, the examiner in charge shall file, under oath, with the Insurance Department a verified written report of examination. Upon receipt of the verified report, the Insurance Department shall transmit the report to the **[**entity**]** company examined, together with a notice that shall afford the **[**entity**]** company examined a reasonable opportunity, not to exceed thirty days, to make a written submission or rebuttal with respect to any matters contained in the examination report. Not later than thirty days after the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and enter an order: (A) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the **[**entity**]** company is operating in violation of any law, regulation or prior order of the commissioner, the commissioner may

order the company to take any action the commissioner considers necessary and appropriate to cure such violation; (B) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refiling pursuant to this subdivision; or (C) calling for an investigatory hearing with not less than twenty days' notice to the company for purposes of obtaining additional documentation, data, information and testimony.

(4) (A) The commissioner shall transmit the examination report adopted pursuant to subparagraph (A) of subdivision (3) of this subsection or a summary thereof to the **[**entity**]** company examined, together with any recommendations or written statements from the commissioner or the examiner. The secretary of the board of directors or similar governing body of the **[**entity**]** company shall provide a copy of the report or summary to each director and shall certify to the commissioner, in writing, that a copy of the report or summary has been provided to each director.

(B) Not later than one hundred twenty days after receiving the report or summary, the chief executive officer or the chief financial officer of the **[**entity**]** company examined shall present the report or summary to the **[**entity's**]** company's board of directors or similar governing body at a regular or special meeting.

(f) (1) All orders entered pursuant to subdivision (3) of subsection (e) of this section shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner workpapers and any written submissions or rebuttals. The findings and conclusions that form the basis of any such order of the commissioner shall be subject to review as provided in section 38a-19.

(2) Any investigatory hearing conducted under subparagraph (C) of

subdivision (3) of subsection (e) of this section by the commissioner or the commissioner's authorized representative, shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent (A) upon the filed examination report, (B) raised by or as a result of the commissioner's review of relevant workpapers, or (C) by the written submission or rebuttal of the company. Not later than twenty days after the conclusion of any such hearing, the commissioner shall enter an order pursuant to subparagraph (A) of subdivision (3) of subsection (e) of this section. The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the **[**entity**]** company limited to the examiner's workpapers that tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or the commissioner's authorized representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation, whether under the control of the department, the **[**entity**]** company or other persons. The documents produced shall be included in the record and testimony taken by the commissioner or the commissioner's authorized representative shall be under oath and preserved for the record. Nothing contained in this section shall require the department to disclose any information or records that would indicate or show the existence or content of any investigation or activity of a criminal justice agency. The hearing shall proceed with the commissioner or the commissioner's authorized representative posing questions to the persons subpoenaed. Thereafter, the **[**entity**]** company and the Insurance Department may present testimony relevant to the investigation. Cross-examination shall be conducted only by the commissioner or the commissioner's authorized representative. The **[**entity**]** company and the Insurance Department shall be permitted to make closing statements and may be represented by counsel of their choice.

(g) The commissioner may, if the commissioner deems it in the public interest, publish any such report, or the result of any such examination contained therein, in one or more newspapers of the state.

(h) The commissioner shall, at least once in every five years, visit and examine the affairs of each domestic **[**insurance company**]** insurer, domestic health care center, domestic fraternal benefit society, and foreign and alien **[**insurance company**]** insurer doing business in this state. Notwithstanding subdivision (1) of subsection (c) of this section, no domestic **[**insurance company**]** insurer or such other domestic entity subject to examination under this section shall pay as costs associated with the examination the salaries, fringe benefits **[**, traveling**]** or travel and maintenance expenses of examining personnel of the Insurance Department engaged in such examination if such domestic **[**company**]** insurer or domestic entity is otherwise liable to assessment levied under section 38a-47, except that a domestic **[**insurance company**]** insurer or such other domestic entity shall pay the **[**traveling**]** travel and maintenance expenses of examining personnel of the Insurance Department when such **[**company**]** insurer or entity is examined outside the state.

(i) Nothing contained in this section shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the Insurance Department of this or any other state or country, or to law enforcement officials of this or any other state or to any agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees, in writing, to hold such report and matters relating thereto confidential.

(j) All workpapers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under this

section shall be **[**given**]** confidential, **[**treatment,**]** shall not be subject to subpoena and shall not be made public by the commissioner or any other person, except to the extent provided in subsection (i) of this section. The commissioner may grant access to such workpapers, recorded information, documents and copies thereof to the National Association of Insurance Commissioners, provided said association agrees, in writing, to hold such workpapers, recorded information, documents and copies thereof confidential.

(k) (1) The commissioner may from time to time engage, on an individual basis, the services of qualified actuaries, certified public accountants or other similar individuals who are independently practicing their professions, even though said persons may from time to time be similarly employed or retained by persons subject to examination under this section.

(2) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this section.

(3) No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative examiner pursuant to an examination made under this section, if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(4) This section shall not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subdivision (2) of this subsection.

(5) A person identified in subdivision (2) of this subsection shall be entitled to an award of attorney's fees and costs if such person is the prevailing party in a civil action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this section and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

Sec. 5. Subsection (b) of section 38a-48 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) On or before July thirty-first, annually, the Insurance Commissioner and the Office of the Healthcare Advocate shall render to each domestic insurance company or other domestic entity liable for payment under section 38a-47: **[**, (1) a**]** (1) A statement **[**which**]** that includes (A) the amount appropriated to the Insurance Department and the Office of the Healthcare Advocate for the fiscal year beginning July first of the same year, (B) the cost of fringe benefits for department and office personnel for such year, as estimated by the Comptroller, (C) the estimated expenditures on behalf of the department and the office from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, and (D) the amount appropriated to the Department on Aging for the fall prevention program established in section 17a-303a from the Insurance Fund for the fiscal year; **[**,**]** (2) a statement of the total taxes imposed on all domestic insurance companies and domestic insurance entities under chapter 207 on business done in this state during the preceding calendar year; **[**,**]** and (3) the proposed assessment against that company or entity, calculated in accordance with the provisions of subsection (c) of this section, provided **[**that**]** for the purposes of this calculation the amount appropriated to the Insurance Department and the Office of the

Healthcare Advocate plus the cost of fringe benefits for department and office personnel and the estimated expenditures on behalf of the department and the office from the Capital Equipment Purchase Fund pursuant to section 4a-9 shall be deemed to be the actual expenditures of the department and the office, and the amount appropriated to the Department on Aging from the Insurance Fund for the fiscal year for the fall prevention program established in section 17a-303a shall be deemed to be the actual expenditures for the program.

Sec. 6. Subdivision (2) of subsection (d) of section 38a-78 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(2) Except as otherwise provided in subsections (e), (f) and (l) of this section, the minimum standard for the valuation of all such policies and contracts issued prior to the effective date specified in accordance with the provisions of subsection (h) of section 38-130e of the general statutes, revision of 1958, revised to 1981, shall be that provided by the laws in effect immediately prior to such date, except that the minimum standard for the valuation of annuities and pure endowments purchased prior to January 1, 1973, under group annuity and pure endowment contracts shall be the 1971 Group Annuity Mortality Table, or any modification of this table approved by the commissioner, and an interest rate of five per cent per annum. Except as otherwise provided in subsections (e), (f) and (l) of this section, the minimum standard for the valuation of all such policies and contracts issued on and after such effective date shall be the commissioners' reserve valuation methods defined in subsections (g), (h) and (j) of this section, with four and one-half per cent interest and the following tables: (A) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the Commissioners' 1958 Standard Ordinary Mortality Table for such policies issued prior to the compliance date established by subdivision

(11) of subsection (e) of section 38a-439, as amended by this act, provided **[**that**]** for any category of such policies issued on female risks, all modified net premiums and present values referred to in this section may be calculated according to an age not more than six years younger than the actual age of the insured and for such policies issued on or after the compliance date established by subdivision (11) of subsection (e) of section 38a-439, as amended by this act, (i) the Commissioners' 1980 Standard Ordinary Mortality Table, (ii) at the election of the company for any one or more specified plans of life insurance, the Commissioners' 1980 Standard Ordinary Mortality Table with ten-year select mortality factors, (iii) on or after January 1, 2005, until January 1, 2009, at the election of the company for any one or more specified plans of life insurance issued on or after January 1, 2004, on the basis of the Commissioners' 2001 Standard Ordinary Mortality Table, except that with respect to such plans issued before April 1, 2005, such mortality table shall be used solely for the basis of valuation and nonforfeiture and shall not be used to increase the previously agreed required premium, (iv) issued on or after January 1, 2009, the Commissioners' 2001 Standard Ordinary Mortality Table, or (v) any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such policies; (B) for all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, the Commissioners' 1961 Standard Industrial Mortality Table or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such policies; (C) for total and permanent disability benefits in or supplementary to ordinary policies or contracts, the tables of period 2 disablement rates

and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such policies. These tables shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies; (D) for accidental death benefits in or supplementary to policies, the 1959 Accidental Death Benefits Table or any accidental death benefits table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations adopted by the commissioner in accordance with the provisions of chapter 54 for use in determining the minimum standard of valuation for such policies. These tables shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; and (E) for group life insurance, life insurance issued on the substandard basis and other special benefits, such tables as may be approved by the commissioner.

Sec. 7. Subdivision (2) of subsection (g) of section 38a-78 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(2) Except as otherwise provided in subsections (h), (j) and (l) of this section, reserves according to the commissioners' reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the

respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of subparagraph (A) of this subdivision over subparagraph (B) of this subdivision, as follows: (A) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided such net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy; and (B) a net one year term premium for such benefits provided for in the first policy year provided **[**that**]** for any life insurance policy issued on or after January 1, 1985, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners' reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in subsection (j) of this section, be the greater of the reserve as of such policy anniversary calculated as described in this subsection and the reserve as of such policy anniversary calculated as described in this subsection but with the value defined in subparagraph (A) of this subdivision being reduced by fifteen per cent of the amount of such excess first year premium, all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed

ending date, the policy being assumed to mature on such date as an endowment, and the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison, the mortality and interest bases stated in subsections (e) and (f) of this section shall be used. Reserves according to the commissioners' reserve valuation method for: (i) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums; (ii) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended; (iii) disability and accidental death benefits in all policies and contracts; and (iv) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of this subsection.

Sec. 8. Subdivision (1) of subsection (b) of section 38a-132 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) (1) Any public hearing held by the commissioner pursuant to **[**subdivision (1) of**]** subsection (a) of this section shall be held not later than thirty days after the statement required by section 38a-130 is filed with the commissioner. The commissioner shall provide at least twenty days' notice of such hearing to the person filing the statement. The person filing the statement shall (A) provide at least seven days' notice of such public hearing to the insurance company and to such other persons as may be designated by the commissioner, (B) publish, in a manner prescribed by the commissioner, notice of such hearing in a

newspaper of general circulation in the city of Hartford and in such other municipality as the commissioner may direct, and (C) provide notice in such other manner as the commissioner deems appropriate under the circumstances. If any amendment to the statement is filed, the commissioner may postpone the public hearing for a reasonable period not to exceed thirty days after the filing of such amendment.

Sec. 9. Subparagraph (A) of subdivision (3) of subsection (o) of section 38a-135 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(A) The place of domicile of the member insurance companies of the internationally active insurance group that **[**hold**]** holds the largest share of such insurance group's premiums, assets or liabilities;

Sec. 10. Subdivision (2) of subsection (c) of section 38a-156a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(2) The reorganizing insurer shall mail a notice of the public hearing to each member at such member's last known mailing address as shown in the insurer's records. The notice shall (A) be mailed at least sixty days prior to the date of the hearing, (B) include the date, time, place and purpose of the hearing, and (C) be accompanied or preceded by a true and complete copy of the proposed plan of reorganization or summary thereof approved by the commissioner and any other explanatory information or materials the commissioner may require. In addition, the reorganizing insurer shall provide notice of the date, time, place and purpose of the hearing by publication in three newspapers having general circulation, one of which shall be in the county in which the principal office of the reorganizing insurer is located, and two **[**which**]** that shall be in other municipalities within or without the state and approved by the commissioner. Such notice shall be published not less than fifteen days and not more than sixty days

prior to the hearing and shall be in a form approved by the commissioner. Any director, officer, employee or member of the reorganizing insurer shall have the right to appear and be heard at the hearing.

Sec. 11. Subdivision (2) of subsection (c) of section 38a-156j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(2) The converting company shall mail a notice of the public hearing to each member at such member's last known mailing address as shown in the company's records. The notice shall (A) be mailed at least sixty days prior to the date of the hearing, (B) include the date, time, place and purpose of the hearing, and (C) be accompanied or preceded by a true and complete copy of the proposed plan of conversion or a summary thereof approved by the commissioner and any other explanatory information or materials the commissioner may require. In addition, the converting company shall provide notice of the date, time, place and purpose of the hearing by publication in three newspapers having general circulation, one of which shall be in the county in which the principal office of the converting company is located, and two **[**which**]** that shall be in other municipalities within or without the state and approved by the commissioner. Such notice shall be published not less than fifteen days and not more than sixty days prior to the hearing and shall be in a form approved by the commissioner. Any director, officer, employee or member of the converting company shall have the right to appear and be heard at the hearing.

Sec. 12. Subsections (a) and (b) of section 38a-194 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) In the event of an insolvency of a health care center, upon order

of the commissioner, all other carriers that participated in the enrollment process with the insolvent health care center at a group's last regular enrollment period shall offer such group's subscribers of the insolvent health care center a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer such subscribers of the insolvent health care center the same coverages and rates that such carrier had offered to the subscribers of the group at its last regular enrollment period for the remainder of the term of the original group contract. An open enrollment shall not be required where the group contract holder participates in a self-insured, self-funded or other health plan exempt from the regulation of the commissioner, unless the plan administrator and group contract holder voluntarily agree to offer a simultaneous open enrollment and extend coverage under the same enrollment terms and conditions as are applicable to carriers under sections 38a-175 to **[**38a-178, inclusive, subsection (a) of section 38a-179, sections 38a-182 to 38a-185**]** 38a-183, inclusive, **[**38a-187, 38a-188 and**]** section 38a-192 **[**to 38a-194, inclusive,**]** and the regulations adopted **[**hereunder**]** under said sections.

(b) If no other carrier has been offered to one or more groups enrolled in the insolvent health care center, or if the commissioner determines that the other carrier or carriers lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health care center, **[**then**]** the commissioner shall allocate equitably the insolvent health care center's group contracts for such groups among all health care centers **[**which**]** that operate within a portion of the insolvent health care center's service area, taking into consideration the health care delivery resources of each health care center. Each health care center, to which a group or groups are so allocated, shall offer such group or groups the health care center's existing coverage **[**which**]** that is most similar to the group's coverage with the insolvent health care center at rates determined in accordance with the successor health care

center's existing rating methodology. No offering by a carrier shall be required where the group contract holder participates in a self-insured, self-funded or other health plan exempt from regulation by the commissioner. The commissioner shall also allocate equitably the insolvent health care center's nongroup enrollees who are unable to obtain other coverage among all health care centers **[**which**]** that operate within a portion of the insolvent health care center's service area, taking into consideration the health care delivery resources of each such health care center. Each health care center to which nongroup enrollees are allocated **[**,**]** shall offer each such nongroup enrollee **[**,**]** the health care center's existing coverage for individual **[**or conversion**]** coverage as determined by **[**his**]** such nongroup enrollee's type of coverage in the insolvent health care center at rates determined in accordance with the successor health care center's existing rating methodology. Successor health care centers **[**which**]** that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

Sec. 13. Subsections (b) and (c) of section 38a-199 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) A hospital service corporation providing health care benefits to plan subscribers under the provisions of subsection (a) of this section may, upon obtaining the approval of the Insurance Commissioner as provided in section 38a-208: (1) Contract for the coordination of benefits with other hospital service corporations, medical service corporations or insurance companies to avoid duplication of benefits to be provided to its group subscribers; (2) make loans, grants or provide anything of value to a health care center covering all or part of the cost of health services provided to members; (3) contract with a health care center to provide insurance or similar protection to cover the cost of care provided through health care centers and to provide

coverage in the event of the insolvency of the health care center; and (4) establish, maintain, own and operate health care centers as a line of business, provided **[**that**]** (A) aggregate investments hereafter made by such corporation shall not exceed ten per cent of such corporation's contingency reserve as of the date of the investment; (B) such investments shall not be repaid or recovered from rates charged by such corporation for its non-health-care-center lines of business; and (C) the commissioner finds, based upon evidence furnished by such corporation, that the financial condition of such corporation and the rates of its non-health-care-center subscribers are not unduly jeopardized by such investment. Subdivision (1) of this subsection shall be subject to such regulations as may be adopted by the Insurance Commissioner, in accordance with the provisions of chapter 54, to establish coordination of benefits clauses in health care contracts.

(c) Each hospital service corporation shall maintain reserves equal in amount to its liabilities under all its policy contracts, as the same are computed in accordance with regulations adopted in accordance with the provisions of chapter 54 upon reasonable consideration of ascertained experience for the purpose of adequately protecting the subscriber and securing the solvency of such company. Each such corporation shall maintain a reserve for contingencies that shall not be less than the amount required by companies licensed to transact accident and health insurance, under section 38a-72. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, prescribing the maximum amount that may be held in the reserve for contingencies, and in adopting such regulations, shall consider the stability, solvency and interests of the corporation and the interests of the subscribers and other affected persons. On and after October 1, 1974, the commissioner may require a hospital service corporation to adjust its reserve for contingencies to comply with the provisions of this section and to adjust its rates or benefits or both to reflect the adjustment in the reserve for contingencies.

Sec. 14. Subsections (b) and (c) of section 38a-214 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) A medical service corporation providing health care benefits to plan subscribers under the provisions of subsection (a) of this section may, upon obtaining the approval of the Insurance Commissioner as provided in section 38a-218: (1) Contract for the coordination of benefits with other hospital service corporations, medical service corporations or insurance companies to avoid duplication of benefits to be provided to its group subscribers; (2) make loans, grants or provide anything of value to a health care center covering all or part of the cost of health services provided to members; (3) contract with a health care center to provide insurance or similar protection to cover the cost of care provided through health care centers and to provide coverage in the event of the insolvency of the health care center; and (4) establish, maintain, own and operate health care centers as a line of business, provided **[**that**]** (A) aggregate investments hereafter made by such corporation shall not exceed ten per cent of such corporation's contingency reserve as of the date of the investment; (B) such investments shall not be repaid or recovered from rates charged by such corporation for its non-health-care-center lines of business; and (C) the commissioner finds, based upon evidence furnished by such corporation, that the financial condition of such corporation and the rates of its non-health-care-center subscribers are not unduly jeopardized by such investment. Subdivision (1) of this subsection shall be subject to such regulations as may be adopted by the Insurance Commissioner, in accordance with the provisions of chapter 54, to establish coordination of benefits clauses in health care benefit contracts.

(c) Each medical service corporation shall maintain reserves equal in amount to its liabilities under all its policy contracts, as the same are

computed in accordance with regulations adopted in accordance with the provisions of chapter 54 upon reasonable consideration of ascertained experience for the purpose of adequately protecting the subscriber or securing the solvency of such company. Each such corporation shall maintain a reserve for contingencies that shall not be less than the amount required by companies licensed to transact accident and health insurance, under section 38a-72. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, prescribing the maximum amount that may be held in the reserve for contingencies, and in adopting such regulations, shall consider the stability, solvency and interests of the corporation, and the interests of the subscribers and other affected persons. On and after October 1, 1974, the commissioner may require a medical service corporation to adjust its reserve for contingencies to comply with the provisions of this section and to adjust its rates or benefits or both to reflect such adjustment in the reserve for contingencies.

Sec. 15. Section 38a-236 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

No nonprofit legal service corporation, as defined in section 38a-230, shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a full schedule of the rates to be paid by the subscriber and has obtained said commissioner's approval thereof. The commissioner may refuse such approval if **[**he**]** the commissioner finds such rates are excessive, inadequate or unfairly discriminatory. No such legal service corporation shall enter into any contract with subscribers unless and until it has filed with the Insurance Commissioner a copy of such contract, including all riders and endorsements thereof, and until the commissioner's approval thereof has been obtained. The Insurance Commissioner shall, within a reasonable time after the filing of any such form, notify such corporation **[**either**]** of **[**his**]** the commissioner's approval or

disapproval thereof.

Sec. 16. Subdivision (1) of section 38a-250 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(1) "Completed operations liability" means liability arising out of the installation, maintenance or repair of any product at a site **[**which**]** that is not owned or controlled by any person who hires an independent contractor to perform that work, and shall include liability for activities **[**which**]** that are completed or abandoned before the date of the occurrence giving rise to the liability;

Sec. 17. Subdivision (5) of section 38a-250 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(5) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance and any other arrangement for shifting and distributing risk **[**which**]** that is determined to be insurance under applicable state or federal law;

Sec. 18. Subdivision (12) of section 38a-250 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(12) "Risk retention group" means any corporation or other limited liability association: (A) Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members; (B) **[**which**]** that is organized for the primary purpose of conducting the activity described under subparagraph (A) of this subdivision; (C) that (i) is chartered and licensed as a liability insurance company under the laws of a state and authorized to engage in the business of insurance under the laws of such state, or (ii) before January 1, 1985, was chartered or licensed and authorized to engage in

the business of insurance under the laws of Bermuda or the Cayman Islands and, before said date, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as such terms were defined in the Product Liability Risk Retention Act of 1981, 15 USC 3901 et seq., before the date of the enactment of the Liability Risk Retention Act of 1986; (D) that does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person; (E) that (i) has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group, or (ii) has as its sole owner an organization **[**which**]** that has as its members only persons who comprise the membership of the risk retention group, and as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; (F) whose members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; (G) whose activities do not include the provision of insurance other than (i) liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its group members, and (ii) reinsurance with respect to the similar or related liability exposure of any other risk retention group, or any member of such other group, that is engaged in businesses or activities so that such group or member meets the requirement described in subparagraph (F) of this subdivision for membership in the risk retention group that provides such reinsurance; and (H) the name of which includes the phrase "Risk Retention Group";

Sec. 19. Section 38a-262 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

The Insurance Commissioner is authorized to make use of any of the powers established under this title to enforce the laws of this state so long as those powers are not specifically preempted by the Product Liability Risk Retention Act of 1981, **[**(15 USC 3901 et seq.)**]** 15 USC 3901 et seq., as amended by the Liability Risk Retention Act of 1986. Such authorization includes, but is not limited to, the commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders and impose penalties. With regard to any investigation, administrative proceedings or litigation, the commissioner may rely on the procedural law and regulations of the state. The injunctive authority of the commissioner in regard to risk retention groups is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

Sec. 20. Section 38a-263 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

Any person acting, or offering to act, as a producer for a risk retention group or purchasing group **[**which**]** that solicits members, sells insurance coverage, purchases coverage for its members located within the state or otherwise does business in this state shall, before commencing any such activity, obtain a license from the Insurance Commissioner in such form as the commissioner prescribes in accordance with the provisions of section 38a-769.

Sec. 21. Section 38a-264 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

A risk retention group **[**which**]** that violates any provision of sections 38a-250 to 38a-266, inclusive, as amended by this act, shall be subject to fines and penalties applicable to licensed insurers generally,

including revocation of its license and the right to do business in this state.

Sec. 22. Subsection (b) of section 38a-308 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) Any policy or contract that includes, either on an unspecified basis as to coverage or for an indivisible premium, coverage against the peril of fire and substantial coverage against other perils need not comply with the provisions of subsection (a) of this section, provided: (1) Such policy or contract shall afford coverage, with respect to the peril of fire, not less than the substantial equivalent of the coverage afforded by said standard fire insurance policy; (2) except as provided under subdivision (1) of subsection (a) of this section for a policy or contract of fire insurance for a commercial property made, issued or delivered by a **[**surplus lines**]** nonadmitted insurer or any agent or representative thereof, the following provisions in said standard fire insurance policy are incorporated therein without change: (A) Mortgagee interests and obligations, (B) the definitions of actual cash value and depreciation, (C) the time period for when a loss is payable after proof of loss, and (D) the time period for when a suit or action for the recovery of a claim may be commenced; (3) such policy or contract is complete as to all of its terms without reference to any other document; and (4) the commissioner is satisfied that such policy or contract complies with the provisions hereof. The provisions of this subsection shall apply to any such policy or contract issued or renewed on or after July 1, 2014.

Sec. 23. Section 38a-310 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

Two or more insurers authorized to do the business of property insurance in this state may, with the approval of the commissioner,

issue a combination standard form of fire insurance policy **[**which**]** that shall contain the following provisions: **[**(a)**]** (1) A provision substantially to the effect that the insurers executing such policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of such insurance under such policy; **[**(b)**]** and (2) a provision substantially to the effect that service of process, or of any notice or proof of loss required by such policy, upon any of the insurers executing such policy, shall be deemed to be service upon all such insurers.

Sec. 24. Section 38a-311 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

**[**Appropriate**]** The commissioner may approve appropriate forms of supplemental contract or contracts or extended coverage endorsements and additional contracts or endorsements, in addition to the perils covered **[**by said**]** under a standard fire insurance policy, **[**may be approved by the commissioner**]** and their use in connection with a standard fire insurance policy. **[**may be authorized by him.**]** The first page of the policy may, in form approved by the commissioner, be rearranged to provide space for the listing of amounts of insurance, rates and premiums for the basic coverages insured under the standard form of policy and for additional coverages or perils insured under supplemental or additional contracts or endorsements, and such other data as may be conveniently included for duplication on daily reports for office records.

Sec. 25. Section 38a-323b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

Each insurer, or designee of an insurer, that denies a claim under a personal risk insurance policy issued in this state shall provide the insured with written notice of the denial. The written notice shall

include the following statement, which shall appear in the final paragraph of the notice in not less than twelve point type: "If you do not agree with this decision, you may contact the Division of Consumer Affairs within the Insurance Department". The notice shall include the address and toll-free telephone number for the division and the Insurance Department's Internet web site address. As used in this section, "personal risk insurance" **[**means personal risk insurance, as defined**]** has the same meaning as provided in section 38a-663.

Sec. 26. Section 38a-341 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

As used in sections 38a-341 to 38a-346, inclusive, as amended by this act:

(1) "Policy" means an automobile liability insurance policy providing among other coverage bodily injury liability, delivered or issued for delivery in this state, insuring a single individual or spouses resident of the same household, as named insured, and under which the insured vehicles therein designated are of the following types only: (A) A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers, nor rented to others, or (B) any other four-wheel motor vehicle with a load capacity of fifteen hundred pounds or less **[**which**]** that is not used in the occupation, profession or business of the insured, provided said sections shall not apply to (i) **[**to**]** any policy insuring more than four automobiles, **[**or**]** (ii) **[**to**]** any policy covering garage, automobile sales agency, repair shop, service station or public parking place operation hazards, or (iii) **[**to**]** any policy of insurance issued principally to cover personal or premises liability of an insured even though the insurance may also provide some incidental coverage for liability arising out of the ownership, maintenance or use of a motor vehicle on the premises of the insured or on the ways immediately adjoining the premises;

(2) "Renewal" or "to renew" means the issuance and delivery by an insurer of a policy replacing at the end of the policy period a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of the policy beyond its policy period or term. Any policy with a policy period or term of less than six months shall, for the purpose of sections 38a-341 to 38a-346, inclusive, as amended by this act, be considered as if written for a policy period or term of six months and any policy written for a term longer than one year or any policy with no fixed expiration date, shall for the purpose of said sections, be considered as if written for successive policy periods or terms of one year. Such a policy may be terminated at the expiration of any annual period upon giving thirty days' notice of cancellation prior to the anniversary date, and such cancellation shall not be subject to any other provisions of said sections;

(3) "Nonpayment of premium" means failure of the named insured to discharge when due any of **[**his**]** such insured's obligations in connection with the payment of premiums on the policy, or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit. Nonpayment of premium includes, but is not limited to, the dishonor of any check, draft or other remittance upon presentment for payment;

(4) "Declination" means: (A) With respect to a producer, denial in whole or in part of an applicant's written request for coverage; failure to submit within a reasonable period of time a completed written application for coverage to a specific insurer **[**which**]** that the producer represents or with which the producer has an account and **[**which**]** that is requested in writing by the applicant; placement of a risk with a residual market, an unauthorized insurer, or an insurer **[**which**]** that specializes in substandard risks; or refusal to provide, upon written

request, an application for coverage; (B) with respect to an insurer **[**which**]** that conducts its business through independent licensed insurance producers, refusal to issue a policy after receipt of a completed written application for coverage from a producer who represents it or from a producer with whom it has an account; or (C) with respect to an insurer other than one specified in subparagraph (B) of this subdivision, refusal to issue a policy after receipt of a completed written application, or refusal to provide, upon written request, an application for coverage.

Sec. 27. Section 38a-343 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) No notice of cancellation of a policy to which section 38a-342 applies shall be effective unless sent, by registered or certified mail or by mail evidenced by a certificate of mailing, or delivered by the insurer to the named insured, and any third party designated pursuant to section 38a-323a, at least forty-five days before the effective date of cancellation, except that (1) where cancellation is for nonpayment of the first premium on a new policy, at least fifteen days' notice of cancellation accompanied by the reason for cancellation shall be given, and (2) where cancellation is for nonpayment of any other premium, at least ten days' notice of cancellation accompanied by the reason for cancellation shall be given. No notice of cancellation of a policy that has been in effect for less than sixty days shall be effective unless mailed or delivered by the insurer to the insured and any third party designee at least forty-five days before the effective date of cancellation, except that (A) at least fifteen days' notice shall be given where cancellation is for nonpayment of the first premium on a new policy, and (B) at least ten days' notice shall be given where cancellation is for nonpayment of any other premium or material misrepresentation. The notice of cancellation shall state or be accompanied by a statement specifying the reason for such

cancellation. Any notice of cancellation for nonpayment of the first premium on a new policy may be retroactive to the effective date of such policy, provided at least fifteen days' notice has been given to the insured and any third party designee and payment of such premium has not been received during such notice period.

(b) Where **[**a private passenger motor vehicle liability insurance company**]** an insurer sends a notice of cancellation under subsection (a) of this section to the named insured of a **[**private passenger motor vehicle liability insurance**]** policy, or a third party designee, such company shall provide with such notice a warning, in a form approved by the Commissioner of Motor Vehicles and the Insurance Commissioner, that informs the named insured that (1) the cancellation will be reported to the Commissioner of Motor Vehicles; (2) the named insured may be receiving one or more mail inquiries from the Commissioner of Motor Vehicles, concerning whether or not required insurance coverage is being maintained, and that the named insured must respond to these inquiries; (3) if the required insurance coverage lapses at any time, the Commissioner of Motor Vehicles may suspend the registration or registrations for the vehicle or vehicles under the policy and the number plates will be subject to confiscation and any person operating any such vehicle will be subject to legal penalties for operating a motor vehicle with a suspended registration; and (4) the named insured will not be able to have the registration restored or obtain a new registration, or any other registration or renewal in the insured's name, except upon presentation to the Commissioner of Motor Vehicles of evidence of required security or coverage and the entering into of a consent agreement with the commissioner in accordance with the provisions of section 14-12g.

(c) If **[**a passenger motor vehicle liability insurance company**]** an insurer cancels a **[**private passenger motor vehicle liability insurance**]** policy pursuant to section 38a-342, such **[**company**]** insurer shall send a

written notice of such cancellation to any lienholder shown on the records of such **[**company**]** insurer as having a legal interest in such motor vehicle.

(d) Subsections (a) and (b) of this section shall not apply to nonrenewal or if the **[**private passenger motor vehicle liability insurance**]** policy is transferred from an insurer to an affiliate of such insurer for another policy with no interruption of coverage and contains the same terms, conditions and provisions, including policy limits, as the transferred policy, except that the insurer to which the policy is transferred shall not be prohibited from applying its rates and rating plans at the time of renewal.

(e) No **[**insurance company**]** insurer that renews, amends or endorses in this state a **[**private passenger motor vehicle liability insurance**]** policy shall charge any fee or other charge exceeding one hundred dollars in the aggregate to an insured who cancels such policy prior to the expiration of such policy.

Sec. 28. Section 38a-343a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) (1) The Commissioner of Motor Vehicles may require each **[**insurance company**]** insurer that issues **[**private passenger motor vehicle liability insurance**]** policies in this state to notify **[**the**]** said commissioner monthly, on a date specified by **[**the**]** said commissioner, of the cancellation by the **[**insurance company**]** insurer of all such policies **[**which**]** that occurred during the preceding month. Such notice shall include the name of the named insured in the policy, the policy number, the vehicle identification number of each automobile covered by the policy and the effective date of the policy's cancellation. **[**The**]** Said commissioner shall specify an acceptable method of notification. The method of notification specified may include computer tapes or electronic transmission.

(2) **[**The**]** Said commissioner may require each **[**insurance company**]** insurer that issues **[**private passenger motor vehicle liability insurance**]** policies in this state to provide monthly, on a date specified by **[**the**]** said commissioner, the policy information required for purposes of the Online Insurance Verification System, as provided in section 14-112a.

(3) The failure of an **[**insurance company**]** insurer to comply with the requirements of this section shall not affect the cancellation of any **[**private passenger motor vehicle liability insurance**]** policy.

(b) The Commissioner of Motor Vehicles shall receive or accept all notices of policy cancellation or all policy information from **[**private passenger motor vehicle liability insurance companies**]** insurers, as required pursuant to subsection (a) of this section. **[**The**]** Said commissioner shall review and analyze the cancellation data or policy information submitted, together with such other information as **[**the**]** said commissioner may obtain from the **[**private passenger motor vehicle liability insurance companies**]** insurers, from the records of the Department of Motor Vehicles, or from any other public or private agency or firm in possession of relevant information, for the purpose of determining whether any registered owner identified in any such notice has failed to continuously maintain insurance coverage in violation of sections 14-12c and 38a-371, as amended by this act. In conducting such an inquiry to determine insured status, **[**the**]** said commissioner may contact registered vehicle owners by mail and require that such mail inquiries be answered in not less than thirty days, in a satisfactory manner containing such information and verification of insurance coverage as **[**the**]** said commissioner **[**shall deem**]** deems necessary and acceptable.

Sec. 29. Section 38a-345 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

When automobile bodily injury and property damage liability

coverage is cancelled, other than for nonpayment of premium, or in the event of failure to renew the policy as provided in section 38a-323, the insurer shall notify the named insured of **[**his**]** such insured's possible eligibility for automobile liability insurance through the automobile liability assigned risk plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew.

Sec. 30. Subsection (f) of section 38a-371 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(f) Upon receipt of a signed written request for suspension from the owner of a registered motor vehicle stating that such vehicle will not be operated upon any highway during a period of not less than thirty consecutive days, the insurer of such vehicle shall suspend, to the extent requested by the owner, insurance coverage afforded under the policy providing the security required by sections 38a-363 to 38a-388, inclusive, for such vehicle until notified by the owner that the coverage should be reinstated. During the period of suspension only, the provisions of subsections (a) to (e), inclusive, of this section shall not apply with respect to such vehicle, **[**provided,**]** except that if such vehicle is operated upon any highway by or with the permission of the owner during the period of suspension, the provisions of said subsections (a) to (e), inclusive, of this section, shall thereupon become applicable. As used in this subsection, "highway" **[**shall be defined**]** has the same meaning as provided in section 14-1. This subsection shall not apply to a motor vehicle for which proof of financial responsibility is required under the provisions of sections 14-112 to 14-133, inclusive.

Sec. 31. Subsection (a) of section 38a-433 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) A domestic life insurance company, including for the purposes

of this section all domestic fraternal benefit societies **[**which**]** that operate on a legal reserve basis, may establish one or more separate accounts and may allocate thereto amounts, including without limitation proceeds applied under optional modes of settlement or under dividend options, to provide for life insurance or life or period-certain annuities, and benefits incidental thereto, payable in fixed or variable amounts or both, or to accumulate funds **[**which**]** that are paid to or held by such company pursuant to section 38a-459, subject to the following: (1) The income, gains and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains or losses of the company; (2) except as may be provided with respect to reserves for guaranteed benefits and funds referred to in subdivision (3) of this subsection, amounts allocated to any separate account and accumulations thereon may be invested and reinvested in any class of loans and investments, and such loans and investments shall not be included in applying the limitations provided in sections 38a-102 to 38a-102h, inclusive; (3) except with the approval of the commissioner and under such conditions as to investments and other matters as **[**he**]** the commissioner may prescribe, which shall recognize the guaranteed nature of the benefits provided, reserves for (A) benefits guaranteed as to dollar amount and duration, and (B) funds guaranteed as to principal amount or stated rate of interest shall not be maintained in a separate account; (4) unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account, provided, that unless otherwise approved by the commissioner, the portion, if any, of the assets of such separate account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in subdivision (3) of this subsection **[**,**]** shall be valued in accordance with the rules otherwise applicable to the company's

assets; (5) amounts allocated to a separate account in the exercise of the power granted by this section shall be owned by the company **[**,**]** and the company shall not be, nor hold itself out to be, a trustee with respect to such amounts. If, and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct; (6) no sale, exchange or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made (A) by a transfer of cash, or (B) by a transfer of securities having a readily determinable market value, provided **[**that**]** such transfer of securities is approved by the commissioner. The commissioner may approve other transfers among such accounts if, in **[**his**]** the commissioner's opinion, such transfers would not be inequitable; (7) to the extent such company deems it necessary to comply with any applicable federal or state laws, such company, with respect to any separate account, including without limitation any separate account **[**which**]** that is a management investment account or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct or the business of such account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants **[**,**]** and the selection of a committee, the members of which need not be otherwise affiliated with such company, to manage the business of such account. The provisions of this subsection shall apply notwithstanding any inconsistent provision in the charter of any such domestic life insurance company or in the

general statutes.

Sec. 32. Subsection (b) of section 38a-439 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by subsection (a) of this section, shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits **[**which**]** that would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of: (1) The then present value of the adjusted premiums as defined in subsections (d) and (e) of this section, corresponding to premiums **[**which**]** that would have become due on and after such anniversary, and (2) the amount of any indebtedness to the company on the policy; provided, **[**that**]** for any policy issued on or after the compliance date established by subdivision (11) of subsection (e) of this section **[**, which**]** that provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value shall be an amount not less than the sum of such value for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and for a policy **[**which**]** that provides only the benefits otherwise provided by such rider or supplemental policy provision; provided **[**,**]** further, **[**that**]** for any family policy issued on or after the compliance date established by subdivision (11) of subsection (e) of this section **[**, which**]** that defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse attains the age of seventy-one, the cash surrender value shall be an amount not less than the sum of such value for an otherwise similar policy issued at the same age without such

term insurance on the life of the spouse and for a policy **[**which**]** that provides only the benefits otherwise provided by such term insurance on the life of the spouse. Any cash surrender value available within thirty days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by subsection (a) of this section, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

Sec. 33. Subsection (e) of section 38a-439 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(e) The provisions of this subsection shall apply to all policies issued on or after the compliance date established by subdivision (11) of this subsection. (1) Except as provided in subdivision (7) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of: (A) The then present value of the future guaranteed benefits provided for by the policy; (B) one per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and (C) one hundred twenty-five per cent of the nonforfeiture net level premium as hereinafter defined, provided **[**that**]** in applying the percentage specified in this subparagraph, no

nonforfeiture net level premium shall be deemed to exceed four per cent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined; (2) the nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits divided by the present value, at such date of issue, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium becomes due; (3) in the case of policies that, on a basis guaranteed in the policy, provide for unscheduled changes in benefits or premiums, or that provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change; (4) except as otherwise provided in subdivision (7) of this subsection, the recalculated future adjusted premiums for any such policy shall be the uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of (A) the sum of: (i) The then present value of the future guaranteed benefits provided for by the policy and (ii) the additional expense allowance, if any, over (B)

the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy; (5) the additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (A) one per cent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (B) one hundred twenty-five per cent of the increase, if positive, in the nonforfeiture net level premium; (6) the recalculated nonforfeiture net level premium shall be equal to the amount obtained by dividing (A) by (B) where (A) equals the sum of (i) the nonforfeiture net level premium applicable prior to the change, multiplied by the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium would have become due had the change not occurred, and (ii) the present value of the increase in future guaranteed benefits provided for by the policy, and (B) equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium becomes due; (7) notwithstanding any other provisions of this subsection, in the case of a policy issued on a substandard basis that provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis that provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis; (8) all adjusted premiums and present values referred to in this section shall be calculated: (A) (i) For all policies of ordinary insurance on the basis of the Commissioners' 1980 Standard Ordinary Mortality Table or at the election of the company, for any one

or more specified plans of life insurance, on the basis of the Commissioners' 1980 Standard Ordinary Mortality Table with ten-year select mortality factors, or (ii) on or after January 1, 2005, until January 1, 2009, at the election of the company for any one or more specified plans of life insurance issued on or after January 1, 2004, on the basis of the Commissioners' 2001 Standard Ordinary Mortality Table, except that with respect to such plans issued before April 1, 2005, such mortality table shall be used solely for the basis of valuation and nonforfeiture and shall not be used to increase the previously agreed required premium, or (iii) for all policies issued on or after January 1, 2009, and prior to the operative date of the Valuation Manual, as set forth in section 38a-78a, on the basis of the Commissioners' 2001 Standard Ordinary Mortality Table, or (iv) for all policies issued on or after the operative date of the Valuation Manual, as set forth in section 38a-78a, on the basis of the Commissioners' Standard Mortality Table, as defined in the Valuation Manual, to determine nonforfeiture values; (B) for all policies of industrial insurance issued (i) prior to the operative date of the Valuation Manual, as set forth in section 38a-78a, on the basis of the Commissioners' 1961 Standard Industrial Mortality Table, or (ii) on or after the operative date of the Valuation Manual, as set forth in section 38a-78a, on the basis of the Commissioners' Standard Mortality Table, as defined in the Valuation Manual, to determine nonforfeiture values. As used in this subdivision and subdivision (9) of this subsection, "Valuation Manual" has the same meaning as provided in subsection (a) of section 38a-78; (C) for all policies issued in a particular calendar year, on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection, for policies issued in that calendar year, provided: **[**, that:**]** (i) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year; (ii) under any paid-up nonforfeiture benefit, including any paid-

up dividend additions, any cash surrender value available, whether or not required by subsection (a) of this section, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any; (iii) a company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values; (iv) in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners' 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners' 1961 Industrial Extended Term Insurance Table for policies of industrial insurance; (v) for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables; (vi) any ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners that are approved by regulations adopted by the commissioner, in accordance with the provisions of chapter 54, for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners' 1980 Standard Ordinary Mortality Table with or without ten-year select mortality factors or the Commissioners' 1980 Extended Term Insurance Table; (vii) any industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners that are approved by regulations adopted by the commissioner, in accordance with the provisions of chapter 54, for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners' 1961 Standard Industrial Mortality Table or the Commissioners' 1961 Industrial Extended Term Insurance Table; (9) the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be, (A) for policies issued prior to the operative date of the

Valuation Manual, as set forth in section 38a-78a, equal to one hundred twenty-five per cent of the calendar year statutory valuation interest rate for such policy as defined in the standard valuation law, rounded to the nearest one quarter of one per cent, except that for policies issued on or after January 1, 2016, such interest rate shall not be less than four per cent if the Valuation Manual is not operative as of said date, and (B) for policies issued on or after the operative date of the Valuation Manual, as set forth in section 38a-78a, as defined in the Valuation Manual; (10) notwithstanding any provision of the general statutes, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form that involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of such policy form; (11) on or after October 1, 1981, but prior to January 1, 1989, any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection on or after a specified date and the provisions of this subsection shall apply to such company on or after such specified date, except that on or after January 1, 2005, but prior to January 1, 2009, any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection on or after a specified date with respect to the Commissioners' 2001 Standard Ordinary Mortality Table and the provisions of this subsection shall apply to such company. The provisions of this subsection shall apply to policies issued by any company on or after January 1, 1989, except that the provisions of this subsection with respect to the Commissioners' 2001 Standard Ordinary Mortality Table shall apply to policies issued by any company on or after January 1, 2009, unless otherwise specified.

Sec. 34. Subsection (a) of section 38a-440 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) This section shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code **[**, as now or hereafter amended**]** of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract **[**which shall be**]** that is delivered outside this state through an agent or other representative of the company issuing the contract.

Sec. 35. Subsection (a) of section 38a-465p of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Any provider or broker lawfully transacting business in this state prior to October 1, 2008, may continue to do so pending approval or disapproval of such provider's or broker's application for a license, provided such application is filed with the commissioner not later than thirty days after October 1, 2008. During the time that such application is pending with the commissioner, the applicant may use any form of life settlement contract that has been filed with the commissioner pending approval thereof, provided **[**that**]** such form is otherwise in compliance with the provisions of this part. Any person transacting business in this state under this provision shall be obligated to comply with all other requirements of this part.

Sec. 36. Subsection (a) of section 38a-472 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Whenever a contract by a third party agency provides for payment to a beneficiary under the contract on account of bills incurred by **[**him**]** such beneficiary for medical, surgical or hospital care received by **[**him**]** such beneficiary, the assignment of the benefits of the contract by **[**that**]** such beneficiary to the department head, as defined in section 4-5, of a state agency, or any doctor or hospital rendering such care, when sent by registered or certified mail to the third party agency, with a copy to the insured, shall be authority for the payment directly by the third party agency to the assignee. The state shall have a lien, in an amount equal to the care rendered, on the proceeds of such contracts for care rendered by any state hospital, institution or other facility, written notice of which shall be authority for the payment directly by the third party agency to the state.

Sec. 37. Subsection (a) of section 38a-472g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) (1) No insurer, health care center, fraternal benefit society, hospital service corporation or medical service corporation or other entity, delivering, issuing for delivery, renewing, amending or continuing an individual or group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 or utilization review company performing utilization review for such insurer, center, society, corporation or entity, that **[**preauthorizes**]** issues prior authorization for or precertifies, on or after January 1, 2012, an admission, service, procedure or extension of stay shall reverse or rescind such **[**preauthorization**]** prior authorization or precertification or refuse to pay for such admission, service, procedure or extension of stay if:

(A) Such insurer, center, society, corporation, entity or company failed to notify the insured's or enrollee's health care provider at least three business days prior to the scheduled date of such admission,

service, procedure or extension of stay that such **[**preauthorization**]** prior authorization or precertification has been reversed or rescinded on the basis of medical necessity, fraud or lack of coverage; and

(B) Such admission, service, procedure or extension of stay has taken place in reliance on such **[**preauthorization**]** prior authorization or precertification.

(2) The provisions of this subsection shall apply regardless of whether such **[**preauthorization**]** prior authorization or precertification is required or is requested by an insured's or enrollee's health care provider. Unless reversed or rescinded as set forth in subparagraph (A) of subdivision (1) of this subsection, such **[**preauthorization**]** prior authorization or precertification shall be effective for not less than sixty days from the date of issuance.

Sec. 38. Section 38a-473 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity **[**which**]** that delivers or issues for delivery Medicare supplement insurance policies or certificates, written, delivered, continued or renewed in this state during the previous calendar year shall incorporate in its rates for Medicare supplement insurance calculated in accordance with sections 38a-495, 38a-495a, as amended by this act, and 38a-522, as amended by this act, and any regulations adopted pursuant to said sections, factors for expenses **[**which**]** that exceed one hundred fifty per cent of the average expense ratio for the entire written premium for all lines of health insurance of such company, society, corporation, center or other entity for the previous calendar year.

(b) No insurance company, fraternal benefit society, hospital service

corporation, medical service corporation, health care center or other entity **[**which**]** that delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate.

Sec. 39. Section 38a-474 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Any insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity **[**which**]** that delivers, issues for delivery, renews, amends or continues in this state any Medicare supplement policy or certificate, as defined in sections 38a-495, 38a-495a, as amended by this act, and 38a-522, as amended by this act, seeking to change its rates shall file a request for such change with the Insurance Department at least sixty days prior to the proposed effective date of such change. The Insurance Department shall review the request and, with respect to requests for an increase in rates, shall hold a public hearing on such increase. The Insurance Commissioner shall approve or deny the request not later than forty-five days after its receipt. The Insurance Commissioner shall adopt regulations, in accordance with chapter 54, to set requirements for the submission of data pertaining to a request to change rates and to define the policies utilized in making a decision on such change in rates.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity **[**which**]** that delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age,

gender, previous claims history or the medical condition of the person covered by such policy or certificate.

Sec. 40. Section 38a-475 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

The Insurance Department shall only precertify long-term care insurance policies **[**which**]** that (1) alert the purchaser to the availability of consumer information and public education provided by the Department on Aging pursuant to section 17b-251; (2) offer the option of home and community-based services in addition to nursing home care; (3) in all home care plans, include case management services delivered by an access agency approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined in regulations adopted pursuant to subsection (e) of section 17b-342, which services shall include, but need not be limited to, the development of a comprehensive individualized assessment and care plan and, as needed, the coordination of appropriate services and the monitoring of the delivery of such services; (4) provide inflation protection; (5) provide for the keeping of records and an explanation of benefit reports on insurance payments which count toward Medicaid resource exclusion; and (6) provide the management information and reports necessary to document the extent of Medicaid resource protection offered and to evaluate the Connecticut Partnership for Long-Term Care. No policy shall be precertified if it requires prior hospitalization or a prior stay in a nursing home as a condition of providing benefits. The commissioner may adopt regulations, in accordance with chapter 54, to carry out the precertification provisions of this section.

Sec. 41. Subdivision (1) of subsection (a) of section 38a-476 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(1) "Health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract. "Health insurance plan" does not include (A) short-term health insurance issued on a nonrenewable basis with a duration of six months or less, accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (B) policies of specified disease or limited benefit health insurance, provided **[**that**]** the carrier offering such policies files on or before March first of each year a certification with the Insurance Commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policies in the state; and (iii) in the case of a policy that is described in this subparagraph and that is offered for the first time in this state on or after October 1, 1993, the carrier files with the commissioner the information and statement required in this subparagraph at least thirty days prior to the date such policy is issued or delivered in this state.

Sec. 42. Section 38a-476a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center shall comply with sections 2742, 2743, and 2747 of the Public Health

Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)**,** **[**(HIPAA),**]** as amended from time to time, concerning guaranteed renewability of individual health insurance coverage and certification of coverage.

(b) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center shall comply with sections 2702, 2704, 2705 and 2712 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191 and 104-204)**,** **[**(HIPAA),**]** as amended from time to time, concerning discrimination based on health status, newborns' and mothers' health, parity of mental health benefits and guaranteed renewability of coverage for employers in the group market, with respect to health insurance coverage offered in the small and large group markets as defined in said Public Health Service Act.

(c) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center shall comply with sections 2711 and 2713 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)**,** **[**(HIPAA),**]** as amended from time to time, concerning guaranteed availability and disclosure of information for employers with respect to health insurance coverage offered in the small group market as defined in said Public Health Service Act.

(d) No provision of the general statutes concerning a **[**HIPAA**]** requirement in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), as amended from time to time, shall be construed to supersede any other provision of the general statutes except to the extent that such other provision prevents the application of a requirement of **[**HIPAA**]** said act.

(e) This section shall apply to insurance companies, fraternal benefit societies, hospital service corporations, medical service corporations

and health care centers on and after the dates specified in the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996, (P.L. 104-191 and 104-204)**,** **[**(HIPAA),**]** as amended from time to time.

(f) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section and the provisions of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Sec. 43. Subdivision (2) of subsection (a) of section 38a-477d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(2) Make available to consumers a way to determine accurately (A) whether a specific prescription drug is available under such policy's drug formulary; (B) the coinsurance, copayment, deductible or other out-of-pocket expense applicable to such drug; (C) whether such drug is covered when dispensed by a physician or a clinic; (D) whether such drug requires **[**preauthorization**]** prior authorization or the use of step therapy; (E) whether specific types of health care specialists are in-network; and (F) whether a specific health care provider or hospital is in-network.

Sec. 44. Subsection (c) of section 38a-477d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(c) The Insurance Commissioner shall post links on **[**its**]** the Insurance Department's Internet web site to any on-line tools or calculators to help consumers compare and evaluate health insurance policies and plans.

Sec. 45. Subsection (a) of section 38a-477e of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) On and after January 1, 2017, each health carrier, as defined in section 38a-1084a, shall maintain an Internet web site and toll-free telephone number that enables consumers to request and obtain: (1) Information on in-network costs for inpatient admissions, health care procedures and services, including (A) the allowed amount for, at a minimum, admissions and procedures reported to the exchange pursuant to section 38a-1084a for each health care provider in the state; (B) the estimated out-of-pocket costs that a consumer would be responsible for paying for any such admission or procedure that is medically necessary, including any facility fee, coinsurance, copayment, deductible or other out-of-pocket expense; and (C) data or other information concerning (i) quality measures for the health care provider, (ii) patient satisfaction, to the extent such information is available, (iii) a directory of participating providers, as defined in section 38a-472f, in accordance with the provisions of section **[**38a-472f**]** 38a-477h; and (2) information on out-of-network costs for inpatient admissions, health care procedures and services.

Sec. 46. Subdivision (8) of subsection (b) of section 38a-478g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(8) **[**Preauthorization**]** Prior authorization and utilization review requirements and procedures, internal grievance procedures and internal and external complaint procedures;

Sec. 47. Subdivision (8) of subsection (a) of section 38a-479qq of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(8) "Person" **[**means a person, as defined**]** has the same meaning as

provided in section 38a-1.

Sec. 48. Subsection (a) of section 38a-482c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall include a lifetime limit on the dollar value of benefits for a covered individual, for covered benefits that are essential health benefits, as defined in the Patient Protection and Affordable Care Act, P.L. **[**111-1448**]** 111-148, as amended from time to time, or regulations adopted thereunder.

Sec. 49. Section 38a-483a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

Notwithstanding the provisions of section 38a-476, as amended by this act, the Insurance Commissioner may adopt regulations, in accordance with the provisions of chapter 54, to allow exclusionary riders to be issued for individual health insurance policies that are not subject to Section 2701 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996, **[**(P.L. 104-191) (HIPAA)**]** P.L. 104-191, as amended from time to time.

Sec. 50. Subsection (a) of section 38a-489 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state **[**more than one hundred twenty days after July 1, 1971,**]** that provides that coverage of a dependent child shall

terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician or advanced practice registered nurse on a form provided by the insurer, hospital service corporation, medical service corporation or health care center, and (2) chiefly dependent upon the policyholder or subscriber for support and maintenance.

Sec. 51. Section 38a-492d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state **[**on or after October 1, 1997,**]** shall provide coverage for laboratory and diagnostic tests for all types of diabetes.

(b) Notwithstanding the provisions of section 38a-492a, each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state **[**on or after October 1, 1997,**]** shall provide medically necessary coverage for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage shall include medically necessary equipment, in accordance with the insured person's treatment plan, drugs and supplies prescribed by a prescribing practitioner, as defined in section 20-571.

Sec. 52. Subsection (a) of section 38a-492e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed or continued in this state **[**on or after January 1, 2000,**]** shall provide coverage for outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if the training is prescribed by a licensed health care professional who has appropriate state licensing authority to prescribe such training. As used in this section, "outpatient self-management training" includes, but is not limited to, education and medical nutrition therapy. Diabetes self-management training shall be provided by a certified, registered or licensed health care professional trained in the care and management of diabetes and authorized to provide such care within the scope of the professional's practice.

Sec. 53. Section 38a-492m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state **[**on or after January 1, 2010,**]** that provides coverage for prescription eye drops, shall not deny coverage for a renewal of prescription eye drops when (1) the renewal is requested by the insured less than thirty days from the later of (A) the date the original prescription was distributed to the insured, or (B) the date the last renewal of such prescription was distributed to the insured, and (2) the prescribing physician, prescribing advanced practice registered nurse or prescribing optometrist indicates on the original prescription that additional quantities are needed and the renewal requested by the insured does not exceed the number of additional quantities needed.

Sec. 54. Section 38a-493 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage providing reimbursement for home health care to residents in this state.

(b) For the purposes of this section **[**, "hospital"**]** and section 38a-494:

(1) "Hospital" means an institution that is primarily engaged in providing, by or under the supervision of physicians, to inpatients **[**(1)**]** (A) diagnostic, surgical and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or **[**(2)**]** (B) medical rehabilitation services for the rehabilitation of injured, disabled or sick persons. **[**, provided "hospital" shall**]** "Hospital" does not include a residential care home, nursing home, rest home or alcohol or drug treatment facility, as defined in section 19a-490; **[**. For the purposes of this section and section 38a-494, "home health care"**]**

(2) "Home health care" means the continued care and treatment of a covered person who is under the care of a physician or an advanced practice registered nurse but only if (A) continued hospitalization would otherwise have been required if home health care was not provided, except in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, and (B) the plan covering the home health care is established and approved in writing by such physician or advanced practice registered nurse within seven days following termination of a hospital confinement as a resident inpatient for the same or a related condition for which the covered person was hospitalized, except that in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, such plan may be so established and approved at any time irrespective of whether such covered person was so confined or, if such covered person was so

confined, irrespective of such seven-day period, and (C) such home health care is commenced within seven days following discharge, except in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live;

(3) "Home health agency" means an agency or organization that meets each of the following requirements: (A) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services; (B) its policies are established by a professional group associated with such agency or organization, including at least one physician or advanced practice registered nurse and at least one registered nurse, to govern the services provided; (C) it provides for full-time supervision of such services by a physician, an advanced practice registered nurse or a registered nurse; (D) it maintains a complete medical record on each patient; and (E) it has an administrator; and

(4) "Medical social services" means services rendered, under the direction of a physician or an advanced practice registered nurse, by a qualified social worker holding a master's degree from an accredited school of social work, including, but not limited to, (A) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment, (B) appropriate action and utilization of community resources to assist in resolving such problems, and (C) participation in the development of the overall plan of treatment for such covered person.

(c) Home health care shall be provided by a home health agency. **[**The term "home health agency" means an agency or organization that meets each of the following requirements: (1) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to

provide nursing and other therapeutic services, (2) its policies are established by a professional group associated with such agency or organization, including at least one physician or advanced practice registered nurse and at least one registered nurse, to govern the services provided, (3) it provides for full-time supervision of such services by a physician, an advanced practice registered nurse or a registered nurse, (4) it maintains a complete medical record on each patient, and (5) it has an administrator.**]**

(d) Home health care shall consist of, but shall not be limited to, the following: (1) Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available; (2) part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a registered or licensed practical nurse; (3) physical, occupational or speech therapy; (4) medical supplies, drugs and medicines prescribed by a physician, advanced practice registered nurse or physician assistant and laboratory services to the extent such charges would have been covered under the policy or contract if the covered person had remained or had been confined in the hospital; (5) medical social services **[**, as hereinafter defined,**]** provided to or for the benefit of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live. **[**Medical social services are defined to mean services rendered, under the direction of a physician or an advanced practice registered nurse by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to (A) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment; (B) appropriate action and utilization of community resources to assist in resolving such problems; (C) participation in the development of the overall plan of treatment for such covered person.**]**

(e) The policy may contain a limitation on the number of home health care visits for which benefits are payable, but the number of such visits shall not be less than eighty in any calendar year or in any continuous period of twelve months for each person covered under a policy or contract, except in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, the yearly benefit for medical social services shall not exceed two hundred dollars. Each visit by a representative of a home health agency shall be considered as one home health care visit **[**;**]** and four hours of home health aide service shall be considered as one home health care visit.

(f) Home health care benefits may be subject to an annual deductible of not more than fifty dollars for each person covered under a policy and may be subject to a coinsurance provision that provides for coverage of not less than seventy-five per cent of the reasonable charges for such services. Such policy may also contain reasonable limitations and exclusions applicable to home health care coverage. A **[**"high deductible health plan"**]** high deductible plan, as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, **[**amended,**]** used to establish a **[**"medical savings account" or "Archer MSA"**]** medical savings account or an Archer MSA pursuant to Section 220 of said Internal Revenue Code or a **[**"health savings account"**]** health savings account pursuant to Section 223 of said Internal Revenue Code shall not be subject to the deductible limits set forth in this subsection.

(g) No policy, except any major medical expense policy as described in subsection (j) of this section, shall be required to provide home health care coverage to persons eligible for Medicare.

(h) No insurer, hospital service corporation or health care center shall be required to provide benefits beyond the maximum amount

limits contained in its policy.

(i) If a person is eligible for home health care coverage under more than one policy, the home health care benefits shall only be provided by that policy that would have provided the greatest benefits for hospitalization if the person had remained or had been hospitalized.

(j) Each individual major medical expense policy delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage in accordance with the provisions of this section for home health care to residents in this state whose benefits are no longer provided under Medicare or any applicable individual health insurance policy.

Sec. 55. Subsection (a) of section 38a-499a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) As used in this section, "telehealth" has the same meaning as provided in section 19a-906.

Sec. 56. Subsections (a) and (b) of section 38a-501 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) (1) As used in this section, "long-term care policy" means any individual health insurance policy delivered or issued for delivery to any resident of this state on or after July 1, 1986, that is designed to provide, within the terms and conditions of the policy, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after an elimination period (A) not to exceed one hundred days of confinement, or (B) of over one hundred days but not to exceed two years of confinement, provided

such period is covered by an irrevocable trust in an amount estimated to be sufficient to furnish coverage to the grantor of the trust for the duration of the elimination period. Such trust shall create an unconditional duty to pay the full amount held in trust exclusively to cover the costs of confinement during the elimination period, subject only to taxes and any trustee's charges allowed by law. Payment shall be made directly to the provider. The duty of the trustee may be enforced by the state, the grantor or any person acting on behalf of the grantor. A long-term care policy shall provide benefits for confinement in a nursing home or confinement in the insured's own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional capacity. "Long-term care policy" **[**shall**]** does not include any such policy that is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(2) (A) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state may refuse to accept, or refuse to make reimbursement pursuant to, a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693, in accordance with subdivision (7) of subsection (a) of section 19a-694, solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(B) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any

long-term care policy in this state shall, upon receipt of a written authorization executed by the insured, (i) disclose information to a managed residential community for the purpose of determining such insured's eligibility for an insurance benefit or payment, and (ii) provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to the insured.

(b) (1) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any long-term care policy that has a loss ratio of less than sixty per cent for any individual long-term care policy. An issuer shall not use or change premium rates for a long-term care policy unless the rates have been filed with and approved by the Insurance Commissioner. Any rate filings or rate revisions shall demonstrate that anticipated claims in relation to premiums when combined with actual experience to date can be expected to comply with the loss ratio requirement of this section. A rate filing shall include the factors and methodology used to estimate irrevocable trust values if the policy includes an option for the elimination period specified in subdivision (1) of subsection (a) of this section.

(2) (A) Any insurance company, fraternal benefit society, **[**health**]** hospital service corporation, medical service corporation or health care center that files a rate filing for an increase in premium rates for a long-term care policy that is for twenty per cent or more shall spread the increase over a period of not less than three years. Such company, society, corporation or center shall use a periodic rate increase that is actuarially equivalent to a single rate increase and a current interest rate for the period chosen.

(B) Prior to implementing a premium rate increase, each such company, society, corporation or center shall:

(i) Notify its policyholders of such premium rate increase and make available to such policyholders the additional choice of reducing the policy benefits to reduce the premium rate. Such notice shall include a description of such policy benefit reductions. The premium rates for any benefit reductions shall be based on the new premium rate schedule;

(ii) Provide policyholders not less than thirty calendar days to elect a reduction in policy benefits; and

(iii) Include a statement in such notice that if a policyholder fails to elect a reduction in policy benefits by the end of the notice period and has not cancelled the policy, the policyholder will be deemed to have elected to retain the existing policy benefits.

Sec. 57. Subsection (a) of section 38a-503a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) No individual health insurance plan **[**, as defined in subdivision (1) of subsection (a) of section 38a-476,**]** or insurance arrangement, as both terms are defined in **[**subdivision (2) of subsection (a) of**]** section 38a-476, as amended by this act, may refuse to cover an individual health insurance applicant due to breast cancer if such applicant has remained free from breast cancer for at least five years prior to the applicant's request for individual health insurance coverage. The individual health insurance carrier may require that the applicant submit to a physical examination.

Sec. 58. Subdivisions (2) to (5), inclusive, of section 38a-505 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(2) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, that specify prohibited policy provisions

not otherwise specifically authorized by statute that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, any person insured under the policy or any beneficiary.

(3) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to establish minimum standards for benefits under each of the following categories of coverage in individual policies: Basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage and specified disease coverage.

(4) Nothing in this section shall preclude the issuance of any policy that combines two or more of the categories of coverage enumerated in subdivision (3) of this section, except that specified accident coverage shall not be combined with any other category of coverage. The commissioner shall prescribe the method of identification of policies based upon coverage provided.

(5) No policy shall be delivered or issued for delivery in this state that does not meet the prescribed minimum standards for the categories of coverage listed in subdivision (3) of this section, provided nothing in this section shall preclude the **[**issuance or**]** delivery or issuance of any policy that does not meet such prescribed minimum standards of coverage so long as such policy is clearly identified as not meeting such prescribed standards.

Sec. 59. Subsection (a) of section 38a-512c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469

delivered, issued for delivery, amended, renewed or continued in this state shall include a lifetime limit on the dollar value of benefits for a covered individual, for covered benefits that are essential health benefits, as defined in the Patient Protection and Affordable Care Act, P.L. **[**111-1448**]** 111-148, as amended from time to time, or regulations adopted thereunder.

Sec. 60. Subsection (a) of section 38a-515 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**more than one hundred twenty days after July 1, 1971,**]** that provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician or advanced practice registered nurse on a form provided by the insurer, hospital service corporation, medical service corporation or health care center, and (2) chiefly dependent upon such employee or member for support and maintenance.

Sec. 61. Section 38a-518d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state **[**on or after October 1, 1997,**]** shall provide coverage for laboratory and diagnostic

tests for all types of diabetes.

(b) Notwithstanding the provisions of section 38a-518a, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state **[**on or after October 1, 1997,**]** shall provide medically necessary coverage for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage shall include medically necessary equipment, in accordance with the insured person's treatment plan, drugs and supplies prescribed by a prescribing practitioner, as defined in section 20-571.

Sec. 62. Subsection (a) of section 38a-518e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed or continued in this state **[**on or after January 1, 2000,**]** shall provide coverage for outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if the training is prescribed by a licensed health care professional who has appropriate state licensing authority to prescribe such training. As used in this section, "outpatient self-management training" includes, but is not limited to, education and medical nutrition therapy. Diabetes self-management training shall be provided by a certified, registered or licensed health care professional trained in the care and management of diabetes and authorized to provide such care within the scope of the professional's practice.

Sec. 63. Section 38a-518*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state **[**on or after January 1, 2010,**]** that provides coverage for prescription eye drops, shall not deny coverage for a renewal of prescription eye drops when (1) the renewal is requested by the insured less than thirty days from the later of (A) the date the original prescription was distributed to the insured, or (B) the date the last renewal of such prescription was distributed to the insured, and (2) the prescribing physician, prescribing advanced practice registered nurse or prescribing optometrist indicates on the original prescription that additional quantities are needed and the renewal requested by the insured does not exceed the number of additional quantities needed.

Sec. 64. Section 38a-520 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage providing reimbursement for home health care to residents in this state.

(b) For the purposes of this section **[**,"hospital"**]** and section 38a-494:

(1) "Hospital" means an institution **[**which**]** that is primarily engaged in providing, by or under the supervision of physicians, to inpatients **[**(1)**]** (A) diagnostic, surgical and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or **[**(2)**]** (B) medical rehabilitation services for the rehabilitation of injured, disabled or sick persons. **[**, provided "hospital" shall**]** "Hospital" does not include a residential care home, nursing home, rest home or alcohol or drug treatment facility, as defined in section 19a-490; **[**. For the purposes of this section and

section 38a-494, "home health care"**]**

(2) "Home health care" means the continued care and treatment of a covered person who is under the care of a physician or an advanced practice registered nurse but only if (A) continued hospitalization would otherwise have been required if home health care was not provided, except in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, and (B) the plan covering the home health care is established and approved in writing by such physician or advanced practice registered nurse within seven days following termination of a hospital confinement as a resident inpatient for the same or a related condition for which the covered person was hospitalized, except that in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, such plan may be so established and approved at any time irrespective of whether such covered person was so confined or, if such covered person was so confined, irrespective of such seven-day period, and (C) such home health care is commenced within seven days following discharge, except in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live;

(3) "Home health agency" means an agency or organization that meets each of the following requirements: (A) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services; (B) its policies are established by a professional group associated with such agency or organization, including at least one physician or advanced practice registered nurse and at least one registered nurse, to govern the services provided; (C) it provides for full-time supervision of such

services by a physician, an advanced practice registered nurse or a registered nurse; (D) it maintains a complete medical record on each patient; and (E) it has an administrator; and

(4) "Medical social services" means services rendered, under the direction of a physician or an advanced practice registered nurse, by a qualified social worker holding a master's degree from an accredited school of social work, including, but not limited to, (A) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment, (B) appropriate action and utilization of community resources to assist in resolving such problems, and (C) participation in the development of the overall plan of treatment for such covered person.

(c) Home health care shall be provided by a home health agency. **[**The term "home health agency" means an agency or organization that meets each of the following requirements: (1) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services, (2) its policies are established by a professional group associated with such agency or organization, including at least one physician or advanced practice registered nurse and at least one registered nurse, to govern the services provided, (3) it provides for full-time supervision of such services by a physician, an advanced practice registered nurse or a registered nurse, (4) it maintains a complete medical record on each patient, and (5) it has an administrator.**]**

(d) Home health care shall consist of, but shall not be limited to, the following: (1) Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available; (2) part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other

than a registered or licensed practical nurse; (3) physical, occupational or speech therapy; (4) medical supplies, drugs and medicines prescribed by a physician, an advanced practice registered nurse or a physician assistant and laboratory services to the extent such charges would have been covered under the policy or contract if the covered person had remained or had been confined in the hospital; (5) medical social services **[**, as hereinafter defined,**]** provided to or for the benefit of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live. **[**Medical social services are defined to mean services rendered, under the direction of a physician or an advanced practice registered nurse by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to (A) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment; (B) appropriate action and utilization of community resources to assist in resolving such problems; (C) participation in the development of the overall plan of treatment for such covered person.**]**

(e) The policy may contain a limitation on the number of home health care visits for which benefits are payable, but the number of such visits shall not be less than eighty in any calendar year or in any continuous period of twelve months for each person covered under a policy, except in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, the yearly benefit for medical social services shall not exceed two hundred dollars. Each visit by a representative of a home health agency shall be considered as one home health care visit **[**;**]** and four hours of home health aide service shall be considered as one home health care visit.

(f) Home health care benefits may be subject to an annual deductible of not more than fifty dollars for each person covered under a policy

and may be subject to a coinsurance provision that provides for coverage of not less than seventy-five per cent of the reasonable charges for such services. Such policy may also contain reasonable limitations and exclusions applicable to home health care coverage. A **[**"high deductible health plan"**]** high deductible plan, as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, **[**amended,**]** used to establish a **[**"medical savings account" or "Archer MSA"**]** medical savings account or an Archer MSA pursuant to Section 220 of said Internal Revenue Code or a **[**"health savings account"**]** health savings account pursuant to Section 223 of said Internal Revenue Code shall not be subject to the deductible limits set forth in this subsection.

(g) No policy, except any major medical expense policy as described in subsection (j) of this section, shall be required to provide home health care coverage to persons eligible for Medicare.

(h) No insurer, hospital service corporation or health care center shall be required to provide benefits beyond the maximum amount limits contained in its policy.

(i) If a person is eligible for home health care coverage under more than one policy, the home health care benefits shall only be provided by that policy that would have provided the greatest benefits for hospitalization if the person had remained or had been hospitalized.

(j) Each major medical expense policy delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage in accordance with the provisions of this section for home health care to residents in this state whose benefits are no longer provided under Medicare or any applicable individual or group health insurance policy.

Sec. 65. Subsection (b) of section 38a-522 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any Medicare supplement policy that has an anticipated loss ratio of less than seventy per cent for any group Medicare supplement policy except that a minimum anticipated loss ratio of seventy-five per cent shall be required for any group Medicare supplement policy defined in Section 1882(g) of Title XVIII of the Social Security Act, 42 USC 1395ss(g), as amended from time to time. No such company, society, corporation or center may deliver or issue for delivery any Medicare supplement policy without providing, at the time of solicitation or application for the purchase or sale of such coverage, full and fair disclosure of any coverage supplementing or duplicating Medicare benefits.

Sec. 66. Subsection (a) of section 38a-526a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) As used in this section, "telehealth" has the same meaning as provided in section 19a-906.

Sec. 67. Subsections (a) and (b) of section 38a-528 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) (1) As used in this section, "long-term care policy" means any group health insurance policy or certificate delivered or issued for delivery to any resident of this state on or after July 1, 1986, that is designed to provide, within the terms and conditions of the policy or certificate, benefits on an expense-incurred, indemnity or prepaid basis

for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after a reasonable elimination period. A long-term care policy shall provide benefits for confinement in a nursing home or confinement in the insured's own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional capacity. "Long-term care policy" **[**shall**]** does not include any such policy or certificate that is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(2) (A) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state may refuse to accept, or refuse to make reimbursement pursuant to, a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693, in accordance with subdivision (7) of subsection (a) of section 19a-694, solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(B) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state shall, upon receipt of a written authorization executed by the insured, (i) disclose information to a managed residential community for the purpose of determining such insured's eligibility for an insurance benefit or payment, and (ii)

provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to the insured.

(b) (1) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any long-term care policy or certificate that has a loss ratio of less than sixty-five per cent for any group long-term care policy. An issuer shall not use or change premium rates for a long-term care policy or certificate unless the rates have been filed with the Insurance Commissioner. Deviations in rates to reflect policyholder experience shall be permitted, provided each policy form shall meet the loss ratio requirement of this section. Any rate filings or rate revisions shall demonstrate that anticipated claims in relation to premiums when combined with actual experience to date can be expected to comply with the loss ratio requirement of this section. On an annual basis, an insurer shall submit to the Insurance Commissioner an actuarial certification of the insurer's continuing compliance with the loss ratio requirement of this section. Any rate or rate revision may be disapproved if the commissioner determines that the loss ratio requirement will not be met over the lifetime of the policy form using reasonable assumptions.

(2) (A) Any insurance company, fraternal benefit society, **[**health**]** hospital service corporation, medical service corporation or health care center that files a rate filing for an increase in premium rates for a long-term care policy that is for twenty per cent or more shall spread the increase over a period of not less than three years. Such company, society, corporation or center shall use a periodic rate increase that is actuarially equivalent to a single rate increase and a current interest rate for the period chosen.

(B) Prior to implementing a premium rate increase, each such company, society, corporation or center shall:

(i) Notify its certificate holders of such premium rate increase and make available to such certificate holders the additional choice of reducing the policy benefits to reduce the premium rate. Such notice shall include a description of such policy benefit reductions. The premium rates for any benefit reductions shall be based on the new premium rate schedule;

(ii) Provide certificate holders not less than thirty calendar days to elect a reduction in policy benefits; and

(iii) Include a statement in such notice that if a certificate holder fails to elect a reduction in policy benefits by the end of the notice period and has not cancelled the policy, the certificate holder will be deemed to have elected to retain the existing policy benefits.

Sec. 68. Subsection (a) of section 38a-530a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) No group health insurance plan **[**, as defined in subdivision (1) of subsection (a) of section 38a-476,**]** or insurance arrangement, as both terms are defined in **[**subdivision (2) of subsection (a) of**]** section 38a-476, as amended by this act, may refuse to cover a group health insurance applicant due to breast cancer if such applicant has remained free from breast cancer for at least five years prior to the applicant's request for group health insurance coverage. The group health insurance carrier may require that the applicant submit to a physical examination.

Sec. 69. Subsection (b) of section 38a-530c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) Each group health insurance carrier that offers maternity benefits shall provide coverage of a minimum of forty-eight hours of

inpatient care for a mother and her newborn infant following a vaginal delivery and a minimum of ninety-six hours of inpatient care for a mother and her newborn infant following a caesarean delivery. The time periods shall commence at the time of delivery.

Sec. 70. Subsection (e) of section 38a-530c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(e) No group health insurance carrier subject to this section shall require prior authorization for the interhospital transfer of (1) a newborn infant experiencing a life-threatening emergency or condition, or (2) the hospitalized mother of such newborn infant to accompany her newborn infant.

Sec. 71. Section 38a-532 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

Any person who is insured under any policy of group health insurance **[**is permitted to**]** may make an assignment of all or any part of **[**his**]** such insured's incidents of ownership in such insurance, including, without limitation, any right to designate a beneficiary or beneficiaries thereunder and any right to have an individual policy issued upon termination either of employment or of said policy of group health insurance, if applicable, **[**provided**]** except that the insurer or group policyholder may prohibit or restrict such assignment by appropriate policy provisions. Such an assignment, subject to the terms of the policy or agreement between the group policyholder and the insurer, is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is to be effective, all rights, benefits and incidents of ownership conferred under the policy and shall entitle the insurer to deal with the assignee as the owner of such rights, benefits and incidents of ownership, provided the insurer shall not be affected by

any assignment until **[**he**]** the insurer has received written notice thereof.

Sec. 72. Subdivision (7) of section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(7) "Health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract. "Health insurance plan" does not include (A) accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (B) policies of specified disease or limited benefit health insurance, provided **[**that**]** the carrier offering such policies files on or before March first of each year a certification with the commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policies in the state; and (iii) in the case of a policy that is described in this subparagraph and that is offered for the first time in this state on or after October 1, 1993, the carrier files with the commissioner the information and statement required in this subparagraph at least thirty days prior to the date such policy is issued or delivered in this state.

Sec. 73. Subdivision (2) of subsection (d) of section 38a-569 of the

general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(2) Any person or member made a party to any action, suit or proceeding because the person or member served on the board or on a committee or was an officer or employee of the pool shall be held harmless and be indemnified by the program against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit or proceeding. The indemnification shall not be provided on any matter in which the person or member is finally adjudged in the action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, wilful misfeasance or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification shall be prorated and paid for by all members. The Insurance Commissioner may retain actuarial consultants necessary to carry out said commissioner's responsibilities pursuant to this section **[**,**]** or section 38a-564, as amended by this act, 38a-566 or 38a-567, and such expenses shall be paid by the pool established in this section.

Sec. 74. Section 38a-582 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) No schedule of charges for enrollee coverage for dental services, or any amendment thereto, may be used by a dental plan organization until a copy of such schedule or amendment has been filed with the commissioner for **[**his**]** the commissioner's approval. The commissioner may disapprove the schedule of charges at any time if **[**he**]** the commissioner finds that the charges are excessive, inadequate or unfairly discriminatory. If the commissioner disapproves the schedule of charges, **[**he**]** the commissioner shall notify the dental plan organization within sixty days of the date of disapproval and specify in the notice the reason for **[**his**]** disapproval. A hearing shall be

granted within twenty days after a request in writing by the dental plan organization is received by the commissioner. It shall be unlawful for any dental plan organization whose schedule of charges has been disapproved to effect any contract or issue any subscription certificate **[**which**]** that uses the disapproved schedule of charges until a revised schedule of charges has been approved. Any dental plan organization aggrieved by the action of the commissioner pursuant to this section may appeal therefrom, in accordance with the provisions of section 4-183.

(b) Charges shall be established in accordance with actuarial principles, but charges applicable to an enrollee shall not be individually determined based on the status of **[**his**]** the enrollee's health.

Sec. 75. Subsection (b) of section 38a-672 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) To obtain and retain a license, a rating organization shall provide satisfactory evidence to the Insurance Commissioner that it will: (1) Permit any admitted insurer to become a member of or a subscriber to such rating organization at a reasonable cost and without discrimination, or withdraw therefrom; (2) neither have nor adopt any rule or exact any agreement, the effect of which would be to require any member or subscriber as a condition to membership or subscribership, to adhere to its rates, rating plans, rating systems, underwriting rules, or policy or bond forms; (3) neither adopt any rule nor exact any agreement the effect of which would be to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers; (4) neither practice nor sanction any plan or act of boycott, coercion or intimidation; (5) neither enter into nor sanction any contract or act by which any person is restrained from

lawfully engaging in the insurance business; (6) notify the Insurance Commissioner promptly of every change in its constitution, its articles of incorporation, agreement or association, and of its bylaws, rules and regulations governing the conduct of its business, its list of members and subscribers and the name and address of the resident of this state designated by it upon whom notices or orders of said commissioner or process affecting such organization may be served; (7) with respect to personal and commercial risk insurance, neither compile for nor distribute to insurers generally, recommendations relating to rates that include profit, general and other acquisition expenses, commission and brokerage, taxes or licenses and fees, nor file rates, supplementary rate information or supporting information on behalf of an insurer that includes profit, general and other acquisition expenses, commission and brokerage, taxes or licenses and fees. **[**, provided that the**]** The provisions of this subdivision may be waived by the Insurance Commissioner when it would be in the public interest and shall not apply to residual markets; and (8) comply with the provisions of section 38a-675, as amended by this act. Any rating organization may, upon the request of any insurer, produce rates for such insurer based upon such insurer's exposure, loss, expense and profit data. The provisions of subdivision (7) of this subsection shall be applicable to services rendered by insurance rating and advisory organizations in relation to workers' compensation insurance on and after October 1, 1989, and to other such services on and after July 1, 1990.

Sec. 76. Subsection (c) of section 38a-673 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(c) With respect to personal and commercial risk insurance, no such advisory organization may compile for or distribute to insurers generally, recommendations relating to rates that include profit, general and other acquisition expenses, commission and brokerage,

taxes or licenses and fees, nor file rates, supplementary rate information or supporting information on behalf of an insurer that includes profit, general and other acquisition expenses, commission and brokerage, taxes or licenses and fees. **[**, provided that the**]** The provisions of this subsection may be waived by the Insurance Commissioner when it would be in the public interest and shall not apply to residual markets. Any advisory organization may, upon the request of any insurer, produce rates for such insurer based upon such insurer's exposure, loss, expense and profit data. The provisions of this subsection shall be applicable to services rendered by insurance rating and advisory organizations in relation to workers' compensation insurance on and after October 1, 1989, and to other such services on and after July 1, 1990.

Sec. 77. Subsection (b) of section 38a-675 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) The Insurance Commissioner shall approve reasonable rules and statistical plans, reasonably adapted to each of the rating systems used, and which shall thereafter be used by each admitted insurer in the recording and reporting of its loss and country-wide expense experience, in order that the experience of all insurers may be made available at least annually. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating of country-wide expense experience. In approving such rules and plans, the commissioner shall give due consideration to the rating systems in use in this state and in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system used by it, **[**provided**]** except that with respect to private passenger nonfleet automobile insurance, the commissioner may

require that claims and loss experience data be allocated, compiled and reported by town. The commissioner may designate one or more rating organizations or other agencies to assist him in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the commissioner, to insurers and rating organizations.

Sec. 78. Subdivision (3) of subsection (b) of section 38a-686 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(3) Risks may be grouped by classifications for the establishment of rates and minimum premiums, provided **[**that**]** with respect to private passenger nonfleet automobile insurance, any change in territorial classifications shall be subject to prior approval by the Insurance Commissioner, and provided no surcharge on any motor vehicle liability or physical damage insurance premium shall be assigned for (A) any accident involving only property damage of one thousand dollars or less, (B) the first accident involving only property damage of more than one thousand dollars which would otherwise result in a surcharge to the policy of the insured, within the experience period set forth in the insurer's safe driver classification plan, (C) any violation of section 14-219 unless such violation results in the suspension or revocation of the operator's license under section 14-111b, (D) less than three violations of section 14-218a within any one-year period, (E) any accident caused by an operator other than the named insured, a relative residing in the named insured's household, or a person who customarily operates the insured vehicle, (F) the first or second accident within the current experience period in relation to which the insured was not convicted of a moving traffic violation and was not at fault, or (G) any motor vehicle infraction. Subparagraph (G) of this subdivision shall not be applicable to any plan established pursuant to section 38a-329. Classification rates may be modified to produce rates

for individual risks in accordance with rating plans that provide for recognition of variations in hazards or expense provisions or both. Such rating plans may include application of the judgment of the insurer and may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.

Sec. 79. Section 38a-688 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) The following procedures shall apply with respect to rates pertaining to personal risk insurance and residual markets:

(1) In a competitive market, every insurer shall file with the commissioner all rates and supplementary rate information to be used in this state, provided **[**that**]** such rates and information need not be filed for inland marine risks **[**which**]** that by general custom of the business are not written according to manual rules or rating plans. No such filings may be made by a rating organization on behalf of any insurer. Such rates and supplementary rate information shall be filed by the effective date of the filing or the date that premium billing notices reflecting the new rates are sent to insureds or agents, whichever is earlier. In a competitive market, if the commissioner finds, after a hearing, that an insurer's rates require closer supervision because of the insurer's financial condition or unfairly discriminatory rating practices, the insurer shall file with the commissioner at least thirty days before the effective date, all such rates and such supplementary rate information and supporting information as prescribed by the commissioner. Upon application by the filer, the commissioner may authorize an earlier effective date for the filing.

(2) In a noncompetitive market, every insurer shall file with the commissioner all rates and supplementary rate information for that market and such supporting information as is required by the commissioner. For purposes of subsection (d) of section 7-479e,

sections 38a-341, as amended by this act, 38a-387, 38a-665, subsection (b) of section 38a-672, as amended by this act, and sections 38a-673, as amended by this act, 38a-675, as amended by this act, 38a-676 and 38a-686 to 38a-694, inclusive, as amended by this act, residual markets, title insurance and credit property insurance are deemed to be noncompetitive markets. All rates and supplementary rate information and such supporting information as is required by the commissioner, shall also be filed with the commissioner for insurance provided pursuant to section 38a-328, 38a-329 or 38a-670. Such rates and supplementary rate information and supporting information required by the commissioner shall be on file with the commissioner for a waiting period of thirty days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed thirty days if the commissioner gives written notice within such waiting period to the insurer or rating organization **[**which**]** that made the filing that the commissioner needs such additional time for the consideration of such filing. Upon written application by such insurer or rating organization, the commissioner may authorize a filing **[**which**]** that the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of sections 38a-663 to 38a-696, inclusive, unless disapproved by the commissioner within the waiting period or any extension thereof. If, within the waiting period or any extension thereof, the commissioner finds that a filing does not meet the requirements of sections 38a-663 to 38a-696, inclusive, the commissioner shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing, specifying therein in what respects the commissioner finds such filing fails to meet the requirements of sections 38a-663 to 38a-696, inclusive, and stating that such filing shall not become effective. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(3) An insurer may file rates by reference, with or without deviation, to rates charged by another insurer **[**which**]** that were filed and are in effect if the insurer's direct written premium for the applicable line of insurance is less than one-half of one per cent of the total state-wide direct written premium for that line, as determined from the annual statements filed by insurers licensed to do business in this state and as calculated by the National Association of Insurance Commissioners from its data base. Supporting information shall not be required for rates filed by reference pursuant to this subsection. For purposes of this subdivision, **[**the term**]** "insurer" **[**shall include**]** includes two or more admitted insurers having a common ownership or operating in this state under common management or control.

(4) Rates filed pursuant to this section shall be filed in such form and manner as is prescribed by the commissioner. Whenever a filing made pursuant to subdivision (1) or (2) of subsection (a) of this section is not accompanied by the information upon which the insurer supports such filing and the commissioner does not have sufficient information to determine whether such filing meets the requirements of sections 38a-663 to 38a-696, inclusive, the commissioner shall require such insurer to furnish the information upon which it supports such filing and in such event the waiting period shall commence as of the date such information is furnished. The information furnished in support of a filing may include (A) the experience or judgment of the insurer making the filing, (B) its interpretation of any statistical data it relies upon, (C) the experience of other insurers, or (D) any other relevant factors.

(5) All rates, supplementary rate information and any supporting information for risks filed under subsection (d) of section 7-479e, sections 38a-341, as amended by this act, 38a-387, 38a-665, subsection (b) of section 38a-672, as amended by this act, and sections 38a-673, as amended by this act, 38a-675, as amended by this act, 38a-676 and 38a-

686 to 38a-694, inclusive, as amended by this act, shall, as soon as filed, be open to public inspection at any reasonable time. Copies may be obtained by any person on request and upon payment of a reasonable charge.

(b) Rates for insurance described in subsection (a) of this section shall be subject to review as follows:

(1) Rates subject to prefiling under subdivision (1) or (2) of subsection (a) of this section may be reviewed and disapproved before their effective date, except that rates for insurance provided pursuant to section 38a-328, 38a-329 and 38a-670 shall not be effective until approved by the commissioner. Any rate may be reviewed and disapproved subsequent to its effective date.

(2) The commissioner may disapprove a rate if the insurer fails to comply with the filing requirements of this section. The commissioner shall disapprove a rate for use in a competitive market if **[**he**]** the commissioner finds that the rate is inadequate or unfairly discriminatory under subsection (a) of section 38a-686. The commissioner shall disapprove a rate for use in a noncompetitive or residual market if **[**he**]** the commissioner finds the rate is excessive, inadequate or unfairly discriminatory under subsection (a) of section 38a-686.

(3) If the commissioner finds that a reasonable degree of competition does not exist in a market in accordance with section 38a-687, **[**he**]** the commissioner may require that the insurers in that market file supporting information with respect to existing rates. If the commissioner believes that such rates may violate any of the requirements of subsection (d) of section 7-479e, sections 38a-341, as amended by this act, 38a-387, 38a-665, subsection (b) of section 38a-672, as amended by this act, or sections 38a-673, as amended by this act, 38a-675, as amended by this act, 38a-676, or 38a-686 to 38a-694,

inclusive, [he] as amended by this act, the commissioner may proceed as provided in section 38a-678. If the commissioner believes that rates in a competitive market violate the inadequacy or unfair discrimination standards in section 38a-686, as amended by this act, or any other applicable requirement of subsection (d) of section 7-479e, section 38a-341, as amended by this act, 38a-387, 38a-665, subsection (b) of section 38a-672, as amended by this act, or sections 38a-673, as amended by this act, 38a-675, as amended by this act, 38a-676, or 38a-686 to 38a-694, inclusive, [he] as amended by this act, the commissioner may require the insurers in that market to file supporting information with respect to existing rates. If after reviewing the supporting information, the commissioner continues to believe that such rates may violate these requirements, [he] the commissioner may proceed as provided in section 38a-678. The commissioner may disapprove, without hearing, rates prefiled pursuant to subdivision (1) or (2) of subsection (a) of this section that have not become effective, provided [that] the insurer whose rates have been disapproved shall be given a hearing pursuant to section 38a-19.

(4) If the commissioner disapproves a rate, [he] the commissioner shall issue an order specifying the respects in which it fails to meet the requirements of subsection (d) of section 7-479e, section 38a-341, as amended by this act, 38a-387, 38a-665, subsection (b) of section 38a-672, as amended by this act, and sections 38a-673, as amended by this act, 38a-675, as amended by this act, 38a-676, and 38a-686 to 38a-694, inclusive, as amended by this act. For rates in effect at the time of the disapproval, the commissioner shall state, within a reasonable period of time, when the further use of such rate in contracts of insurance made thereafter shall be prohibited. The commissioner shall issue such order [shall be issued within] not later than thirty days after the hearing or within such reasonable time extension as the commissioner may determine. Such order may include a provision for premium

adjustment for the period after the effective date of the order for policies in effect on such date.

(5) Whenever an insurer has no legally effective rates as a result of the commissioner's disapproval of rates or other act, the commissioner shall specify interim rates. Upon appeal from any such order of the commissioner the court may, upon request of the appealing insurer, stay such order, provided **[**that**]** the insurer places in an escrow account the difference, as received, between the disapproved rates and the interim rates specified by the commissioner. When new rates become legally effective, the commissioner shall order the escrowed funds to be distributed appropriately, with interest at the legal rate as provided in section 37-1, except that minimal refunds to policyholders are not required to be distributed.

Sec. 80. Section 38a-702a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

As used in this chapter and chapter 702, unless the context or subject matter otherwise require:

(1) "Agent" or "insurance agent" means an insurance producer appointed by an insurer to act on the insurer's behalf pursuant to section 38a-702m.

(2) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(3) "Commissioner" means the Insurance Commissioner.

(4) "Home state" means any state or territory of the United States, including, but not limited to, the District of Columbia, in which an insurance producer maintains the producer's principal place of residence or principal place of business and is licensed to act as an

insurance producer.

(5) "Insurance" means any of the lines of authority contained in this title.

(6) "Insurance producer" or "producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

(7) "Insurer" **[**means "insurer", as defined**]** has the same meaning as provided in section 38a-1.

(8) "License" means a document issued by the commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier.

(9) "Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the commissioner determines should be designated a form of limited line credit insurance.

(10) "Limited line credit insurance producer" means a person who sells, solicits or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group or individual policy.

(11) "Limited lines insurance" means **[**those lines of insurance referred to in section 38a-782**]** credit insurance and travel insurance, or any other line of insurance that the commissioner deems necessary to

recognize for the purpose of complying with section 38a-702g.

(12) "Limited lines producer" means a person authorized by the commissioner to sell, solicit or negotiate limited lines insurance.

(13) "Negotiate" means the act of conferring directly with, or offering advice directly to, a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(14) "Person" means an individual or a business entity.

(15) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(16) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(17) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance.

(18) "Uniform business entity application" means the National Association of Insurance Commissioners uniform business entity application for resident and nonresident business entities, as amended from time to time.

(19) "Uniform application" means the National Association of Insurance Commissioners uniform application for resident and nonresident producer licensing, as amended from time to time.

Sec. 81. Subsection (c) of section 38a-712 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective*

*October 1, 2017*):

(c) The commissioner may adopt such reasonable regulations as **[**he**]** the commissioner deems necessary for the implementation of this section and specifically to provide procedures for continuing, terminating or restoring the licenses affected.

Sec. 82. Subsection (a) of section 38a-716 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) If any insurance producer advances, on behalf of an insured, premium for a policy to an insurer, **[**on behalf of an insured,**]** with respect to any property or casualty insurance policy other than one providing coverage for homeowners, tenants, private passenger nonfleet automobile, mobile manufactured home and other property and casualty insurance for personal, family or household needs and such insured has not paid the premium due, the producer may request cancellation of such policy by the insurer, provided **[**that**]** the producer has sent, by certified or registered mail, return receipt requested, to the insured at the address shown on the policy, a written notice **[**which shall include**]** that includes: (1) The name and address of the insured and the insurer, (2) policy number, (3) an itemization of the premium due the insurance producer stated separately for each policy or endorsement, including separate itemization of all payments received for and credits applied to, each policy, (4) a statement of the insurance producer's intent to request, in writing, cancellation of the policy by the insurer for nonpayment of premium, unless the default is cured **[**within**]** not later than fifteen days **[**from**]** after the date the notice is postmarked, (5) a statement specifying that in the event the insured submits any written response to the notice, it shall be forwarded to the insurer with the request for cancellation. If written response is received following submission of written request for cancellation, it shall be immediately forwarded to the insurer by the insurance producer. The

insurer shall reply directly to the insured **[**within**]** not later than ten days **[**following**]** after receipt of the insured's response and forward a copy of its response to the producer.

Sec. 83. Subsection (f) of section 38a-720j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(f) Any license issued to a third-party administrator shall be in force until September thirtieth of each year, unless sooner revoked or suspended as provided in this section. The license may be renewed, at the discretion of the commissioner, upon payment of the fee specified in section 38a-11, and submission of the renewal filing under section 38a-720*l*, as amended by this act.

Sec. 84. Subsection (a) of section 38a-720*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Each third-party administrator seeking to renew a license issued pursuant to section 38a-720j, as amended by this act, shall submit a renewal filing in the form and **[**contain**]** containing such information as the commissioner prescribes, including evidence that the surety bond required under subdivision (1) of subsection (a) of section 38a-720j and, if applicable, subsection (h) of section 38a-720j, remain in force. The information contained in such **[**report**]** renewal filing shall be verified by at least two officers of the third-party administrator.

Sec. 85. Subsection (a) of section 38a-775 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) As used in this section:

(1) "Bank" has the same meaning as **[**set forth**]** provided in section

36a-2, but does not include a trust company that does not accept federally insured deposits and does not engage in insurance sales or solicitation activities, either directly or indirectly through a third-party marketing organization, that would require such trust company to obtain an insurance producer's license under the laws of this state;

(2) "Out-of-state bank" has the same meaning as **[**set forth**]** provided in section 36a-2, provided the institution (A) maintains in this state a branch, as defined in section 36a-410, or (B) engages in insurance sales or solicitation activities, either directly or indirectly through a third-party marketing organization, that would require the institution to obtain an insurance producer's license under the laws of this state, but does not include a trust company that does not accept federally insured deposits and does not engage in insurance sales or solicitation activities, either directly or indirectly through a third-party marketing organization, that would require such trust company to obtain an insurance producer's license under the laws of this state;

(3) "Subsidiary" has the same meaning as **[**set forth**]** provided in section 36a-2;

(4) "Insurance" has the same meaning as **[**set forth**]** provided in section 38a-1, but does not include title insurance;

(5) "Customer" means any person who establishes a deposit, trust, investment, loan or credit account with a bank, out-of-state bank or subsidiary of such bank or out-of-state bank;

(6) "Insurance information" means copies of, or the information contained in, insurance policies, binders, rates, declaration pages and expiration dates that are acquired by a bank, out-of-state bank or subsidiary of such bank or out-of-state bank in connection with its lending activities; and

(7) "Insurance producer" has the same meaning as **[**set forth**]**

provided in section 38a-702a, as amended by this act.

Sec. 86. Subdivision (1) of subsection (d) of section 38a-790 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(1) "Motor vehicle" **[**is defined**]** has the same meaning as provided in section 14-1;

Sec. 87. Subdivision (11) of section 38a-838 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(11) "United States" has the same meaning **[**assigned to it by**]** as provided in section 38a-1.

Sec. 88. Subdivision (16) of section 38a-862 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(16) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. "Premiums" does not include (A) any amounts or considerations received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsection (f) of section 38a-860, except that assessable premium shall not be reduced on account of subparagraph (C) of subdivision (2) of subsection (f) of section 38a-860, relating to interest limitations, and subdivision (2) of subsection (g) of section 38a-860, relating to limitations with respect to any one individual, any one participant and any one contract owner; provided **[**that**]** further, "premiums" **[**shall**]** does not include any premiums in excess of five million dollars on any unallocated annuity contract not issued under a governmental retirement benefit plan established under Section 401,

403(b) or 457 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, or (B) with respect to multiple nongroup policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars with respect to such policies or contracts, regardless of the number of policies or contracts held by the owner;

Sec. 89. Subsection (c) of section 38a-939 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(c) Except as provided in this section, a claim may not share in a distribution of assets pursuant to this chapter unless it has been definitely determined, proved and allowed. A contingent, unliquidated or immature claim may share in a distribution of assets provided, **[**that,**]** as of the time of the allowance or disallowance of the claim by the court: (1) If the claim was a contingent claim against the insurer as of the date established under section 38a-920, the claimant has presented proof of the insurer's obligation to pay reasonably satisfactory to the receiver; (2) if the claim was a contingent claim as of the date established under section 38a-920 and was based upon a cause of action against an insured of the insurer, (A) it may be reasonably inferred from proof presented upon the claim that the claimant would be able to obtain a judgment, (B) the person has furnished suitable proof, unless the court for good cause shown shall otherwise direct, that no further valid claims can be made against the insurer arising out of the cause of action other than those already presented, and (C) the total liability of the insurer to all claimants arising out of the same act shall be no greater than its total liability would be were it not in liquidation. In those cases under subparagraph (C) of this subdivision,

insureds may include in contingent claims reasonable attorney's fees for services rendered after the date of liquidation, in defense of claims or suits covered by the insured's policy, provided the attorney's fees have been paid by the insured and evidence of payment is presented to the receiver; (3) if the claim was unliquidated as of the date established under section 38a-920, its amount has been determined, provided such determination does not prejudice the orderly administration of the liquidation proceeding; or (4) if the claim was immature as of the date established under section 38a-920, it shall be discounted at the higher of the legal rate of interest accruing on judgments or the rate of interest available on United States Treasury securities of approximately the same maturity.

Sec. 90. Subsection (e) of section 38a-941 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(e) The courts of this state may make special rules of civil procedure for disputed claims, provided **[**that**]** the rules are not inconsistent with this chapter.

Sec. 91. Subdivision (2) of subsection (a) of section 38a-944 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(2) Class 2. The administrative expenses of guaranty associations. For purposes of this section such expenses shall be those reasonable expenses incurred by guaranty associations where the expenses are not payments or expenses **[**which**]** that are required to be incurred as direct policy benefits in fulfillment of the terms of the insurance contract or policy, and that are of the type and nature that, but for the activities of the guaranty association otherwise would have been incurred by the receiver, including, but not limited to, evaluations of policy coverage, activities involved in the adjustment and settlement of

claims under policies, including those of in-house or outside adjusters, and the reasonable expenses incurred in connection with the arrangements for ongoing coverage through transfer to other insurers, policy exchanges or maintaining policies in force. The receiver may in his or her sole discretion approve as an administrative expense under this section any other reasonable expenses of the guaranty association if the receiver finds: (A) The expenses are not expenses required to be paid or incurred as direct policy benefits by the terms of the policy, and (B) the expenses were incurred in furtherance of activities that provided a material economic benefit to the estate as a whole, irrespective of whether the activities resulted in additional benefits to covered claimants. The court shall approve such expenses unless it finds the receiver abused his or her discretion in approving the expenses. If the receiver determines that the assets of the estate will be sufficient to pay all class 1 claims in full, class 2 claims shall be paid currently, provided **[**that**]** the liquidator shall secure from each of the associations receiving disbursements pursuant to this section an agreement to return to the liquidator such disbursement, together with investment income actually earned on such disbursements, as may be required to pay class 1 claims. No bond shall be required of any such association.

Sec. 92. Subsection (a) of section 38a-944a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) Notwithstanding any provision of sections 38a-903 to 38a-961, inclusive, including any provision permitting the modification of contracts, or other law of a state, no person shall be stayed or prohibited from exercising: (1) A contractual right to terminate, liquidate or close out any netting agreement or qualified financial contract with an insurer because of: (A) The insolvency, financial condition or default of the insurer at any time, provided **[**that**]** the right

is enforceable under applicable law other than sections 38a-903 to 38a-961, inclusive, or (B) the commencement of a formal delinquency proceeding under sections 38a-903 to 38a-961, inclusive; **[**. (2) Any**]** (2) any right under a pledge, security, collateral or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract; **[**. (3) Subject**]** or (3) subject to any provision of subsection (b) of section 38a-932, any right to set off or net out any termination value, payment amount, or other transfer obligation arising under or in connection with a netting agreement or qualified financial contract where the counterparty or its guarantor is organized under the laws of the United States or a state or foreign jurisdiction approved by the Securities Valuation Office of the National Association of Insurance Commissioners as eligible for netting.

Sec. 93. Subsection (b) of section 38a-985 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) Upon receipt of a written request within ninety business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurance institution or agent shall furnish such person **[**within**]** not later than twenty-one business days **[**from**]** after the date of receipt of such written request: (1) The specific reason for the adverse underwriting decision, in writing, if such information was not initially furnished in writing pursuant to subdivision (1) of subsection (a) of this section; (2) the specific items of personal and privileged information that support those reasons, **[**provided**]** except that: (A) The insurance institution or agent shall not be required to furnish specific items of privileged information if it has a reasonable suspicion, based upon specific information available for review by the commissioner, that the applicant, policyholder or

individual proposed for coverage has engaged in criminal activity, fraud, material misrepresentation or material nondisclosure, and (B) specific items of medical-record information supplied by a medical-care institution or medical professional shall be disclosed either directly to the individual to whom the information relates or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates; and (3) the names and addresses of the institutional sources that supplied the specific items of information pursuant to subdivision (2) of subsection (b) of this section, **[**provided**]** except that the identity of any medical professional or medical-care institution shall be disclosed either directly to the individual or to the designated medical professional.

Sec. 94. Subsection (b) of section 38a-995 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) An insurance institution, agent or insurance-support organization **[**which**]** that discloses information in violation of section 38a-988 shall be liable for damages sustained by the individual concerning whom the information relates, **[**provided**]** except that no individual shall be entitled to a monetary award **[**which**]** that exceeds the actual damages sustained by **[**him**]** such individual as a result of a violation of section 38a-988.

Sec. 95. Subdivision (3) of subsection (e) of section 38a-1081 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(3) Any employee of the exchange whose primary purpose is to assist individuals or small employers in selecting health insurance plans offered **[**on**]** through the exchange to purchase shall be licensed as an insurance producer under chapter 701a not later than eighteen

months after such employee begins employment with the exchange.

Sec. 96. Subsection (c) of section 53a-215 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(c) For the purposes of this section, "insurance company" **[**means "insurance company" as defined**]** has the same meaning as provided in section 38a-1.

Sec. 97. Section 38a-507 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6) and (11) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for services rendered by a chiropractor licensed under chapter 372 to the same extent coverage is provided for services rendered by a physician, if such chiropractic services (1) treat a condition covered under such policy, and (2) are within those services a chiropractor is licensed to perform.

Sec. 98. Subdivision (8) of subsection (a) of section 38a-88a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(8) "Income year" means (A) with respect to corporations subject to taxation under chapter 208, the income year as determined under said chapter, (B) with respect to insurance companies, hospital service corporations and medical **[**services**]** service corporations subject to taxation under chapter 207, the income year as determined under said chapter, and (C) with respect to taxpayers subject to taxation under chapter 229, the taxable year determined under chapter 229;

Sec. 99. Subdivision (7) of subsection (a) of section 38a-495a of the

general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(7) "Medicare supplement policy" means (A) a group or individual policy of accident and sickness insurance or (B) a subscriber contract of hospital **[**and**]** service corporations, medical service corporations or health care centers, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, **[**(42 USC Section 1395 et seq.)**]** 42 USC 1395 et seq., or (C) an issued policy under a demonstration project specified in 42 USC **[**Section**]** 1395ss(g)(1), **[**which**]** that is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

Sec. 100. Subsection (a) of section 38a-495b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) As used in sections 38a-473, as amended by this act, 38a-474, as amended by this act, and 38a-481, subsection (l) of section 38a-495a, sections 38a-495c and 38a-513 and this section, "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended from time to time (Title I, Part I of P.L. 89-97). For policies or certificates delivered or issued for delivery to any resident of this state who is eligible for Medicare, prior to July 30, 1992, "Medicare supplement policy" means any individual or group health insurance policy or certificate delivered or issued for delivery to any resident of the state who is eligible for Medicare, except any long-term care policy as defined in sections 38a-501, as amended by this act, and 38a-528, as amended by this act. For policies or certificates delivered or issued for delivery to any resident on or after July 30, 1992, "Medicare supplement policy" means (A) a group or individual policy of accident and sickness insurance or (B) a subscriber contract of hospital **[**and**]** service corporations, medical service corporations or

health care centers, other than a policy issued pursuant to a contract under Section 1876 or Section 1833 of the federal Social Security Act, **[**(42 USC Section 1395 et seq.)**]** 42 USC 1395 et seq., or (C) an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, **[**which**]** that is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

Sec. 101. Subsection (a) of section 38a-579 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) The commissioner shall issue a certificate of authority if **[**he**]** the commissioner is satisfied that the following conditions are met: (1) The persons responsible for conducting the affairs of the dental plan organization are competent and professionally capable of providing, arranging for or administering the services offered by the plan; (2) the dental plan organization constitutes an appropriate mechanism to achieve an effective dental plan, as determined by the commissioner; (3) the dental plan organization has demonstrated the potential to provide dental services in a manner that will assure both availability and accessibility of adequate personnel and facilities; (4) the dental plan organization has arrangements for an ongoing quality of dental care assurance program; (5) the dental plan organization has a procedure to establish and maintain uniform systems of cost accounting and reports and audits that meet the requirements of the commissioner; (6) the dental plan organization is financially responsible and may reasonably be expected to meet its obligations to enrollees. In making this determination the commissioner shall consider (A) the financial soundness of the dental plan's arrangements for services and the schedule of charges used, (B) any arrangement with an insurer, **[**or**]** a hospital **[**or**]** service corporation, a medical

service corporation or a dental service corporation for continuation of coverage in the event of discontinuance of the plan on an indemnity basis through a group vehicle to the end of the period for which premiums were paid to the discontinued dental plan organization, and (C) the sufficiency of an agreement with dentists for the provision of dental services; (7) whether a general surplus is maintained as required in section 38a-580; and (8) the condition or methods of operation of the dental plan organization are not such as would render its operations hazardous to its enrollees or the public.

Sec. 102. Subsection (d) of section 38a-495a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(d) Except as otherwise specifically provided in subdivision (4) of subsection (l) of this section, the provisions of this section shall not apply to insurance policies or health care benefit plans **[**, including group conversion policies,**]** provided to Medicare eligible persons which policies are not marketed or held to be Medicare supplement policies or benefit plans.

Approved May 31, 2017